No. 91-1283

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

—v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether "any right" in ERISA section 510 applies to all rights provided to a participant or beneficiary by a benefit plan at the time of the contested action, and not merely to vested or "permanent" rights?

2. Whether "discriminate" in ERISA section 510 applies to incidents of retaliation or interference with rights by means of alteration of the terms of a benefit plan?

3. Whether a defense based on a plan sponsor's effort to save costs is unavailable as an absolute defense to an ERISA section 510 claim?

4. Whether ERISA section 510 protects plan participants and beneficiaries against discrimination by means of a disease-specific benefit cap, where that cap has been adopted to retaliate against or interfere with the rights under a plan of a specific individual or specific group of individuals?

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FRANK GREENBERG, Independent Executor
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Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

Petitioner, Frank Greenberg, respectfully petitions this Court for a Writ of Certiorari to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

On June 28, 1990, the United States District Court for the Southern District of Texas (Black, J.) entered an opinion granting summary judgment for the defendants. The decision of the district court is reported at 742 F. Supp. 392 and is set forth at p. A34 of the Appendix. The opinion of the Court of Appeals affirming the judgment is published at 946 F.2d 401 and is set forth at p. A1 of the Appendix.

JURISDICTION

The judgment of the Court of Appeals was entered on November 4, 1991. Jurisdiction in this Court is invoked under 28 U.S.C. § 1254(1). This petition is timely under 28 U.S.C. § 2101(c).

PERTINENT STATUTE

Plaintiff's claims arise under Section 510 of the Employee Retirement Income

Security Act of 1974 ("ERISA"), Publication Number 93-406, 88 Stat. 832 (29 U.S.C. § 1140)("section 510") which provides in pertinent part as follows:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act [29 U.S.C.A. § 301 et seq.], or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. ... The provisions of section 1132 of this title shall be applicable in the enforcement of this section.

STATEMENT OF THE CASE

A. Nature of the Case

In August 1989, plaintiff John McGann, who had been diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS"), commenced this lawsuit to remedy the retaliatory and discriminatory actions taken against him by the defendants, H&H Music Company ("H&H Music" or "McGann's employer"), Brook Mays Music Company ("Brook Mays") and General American Life Insurance Company ("General American") (collectively "the Company"). McGann alleged in his Complaint that, shortly after he submitted claims under the Company's group insurance plan and the Company learned of his illness, the Company conspired to deprive him of further insurance coverage in violation of section 510 of ERISA.

On June 26, 1990, without any discovery having taken place, the district court issued a five-page Order granting summary judgment for the Company. The court ruled that under ERISA the Company had the absolute right to change its group medical insurance plan. The district court also held that the Company did not discriminate against McGann.

The Fifth Circuit affirmed this decision on the grounds that the plaintiff did not adduce evidence of a "right" under the plan, reasoning that the plan allowed for the termination of its terms. The court also found that summary judgment was appropriate because Congress allowed employers discretion to fashion the terms of welfare benefit plans.

B. Facts

McGann had worked for H&H Music since 1982. Until August 1, 1988, one of the critical benefits provided through H&H Music's parent, Brook Mays, to its employees, including McGann, was group medical insurance coverage. The insurance policy, issued by General American, provided for lifetime medical benefits of $1,000,000 to all employees.

In December 1987, McGann was hospitalized for pneumonia. At that time, he learned that he had AIDS. Although personally devastated by this tragic news, McGann took comfort from his knowledge that his medical costs would be substantially covered through his employer-sponsored group health plan.

In late 1987 or early 1988, McGann submitted his first claims for the treatment of his illness. When he

returned to work, McGann informed his employer that he had AIDS. Following the news of his diagnosis, a meeting took place in March 1988 with Company officials and McGann during which McGann's illness was discussed.

Four months after this meeting, the Company issued a letter to employees informing them that, effective August 1, 1988, changes would be made in their medical coverage. In particular, the Company imposed a cap on treatment of AIDS-related illnesses, reducing coverage from $1,000,000 "to $5,000 per individual life time." No such restriction was placed on any other catastrophic illnesses. No other employee was immediately affected by the change of policy.

In accordance with the letter, on August 1, 1988, the Company terminated

its original group insurance plan with General American and replaced it with a self-insured plan. As the letter to employees stated, the plan underwent only minor modifications except for the imposition of a restriction on coverage for AIDS and AIDS-related illnesses -- from $1,000,000 to $5,000[1] -- a

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[1] Under the new plan, AIDS is defined as:

> Acquired Immune Deficiency Syndrome (AIDS): means illness or injury including, but not limited to, the following:
>
> a) pneumonia,
> b) pneumocystis carinii pneumonia,
> c) helminthic infections,
> d) fungal infections,
> e) viral infections,
> f) bacterial infections,
> g) Karposis [sic] sarcoma or other malignancy,
> h) disorder of the body's immune defense system, and
> i) AIDS-related dementia
>
> in connection with exposure to or infection by the HIV or similar virus, as demonstrated by

(continued...)

restriction that immediately affected only McGann. General American administers the new plan.

On August 26, 1988, an agent for General American met with a number of H&H Music employees, including McGann, to discuss the new policy. During that meeting, the agent stated that the change in insurance coverage was the product of three months of negotiation by Company officials. During that same meeting, General American's agent told McGann that there was no way McGann could purchase continuing medical coverage as an individual.

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[1](...continued)
generally recognized blood or diagnostic tests.

AIDS Related Complex (ARC): means two signs or symptoms and two or more laboratory findings consistent with AIDS.

The Company, for purposes of the summary judgment motion, conceded that it intended to terminate the original plan and replace it with the self-insured plan because the Company knew of and did not want to continue to pay for treatment of McGann's illness.

The district court granted summary judgment for the Company. It ruled that the Company has an absolute right to alter the terms of its welfare benefit plans, regardless of its motive in making the changes. Without any discovery having been taken, the district court accepted the Company's defense of cost-savings as a non-discriminatory reason for its action.

C. Court of Appeals Ruling

On appeal, a panel of the Fifth Circuit affirmed the judgment on the grounds that:

(1) the Company's mere assertion of a cost-savings rationale was adequate to satisfy the court that despite its assumption of "a connection between the benefits reduction and either McGann's filing of claims or McGann's revelations about his illness," the Company's actions did not violate section 510;

(2) McGann did not adduce evidence of a "right" under the welfare benefit plan because the plan did not guarantee "permanent" benefits; and

(3) notwithstanding the plain language of section 510, McGann's claim conflicts with the employer's discretion to set the terms of benefit plans.

REASONS FOR GRANTING THE PETITION

POINT I

THE FIFTH CIRCUIT'S NOVEL AND RESTRICTIVE APPLICATION OF SECTION 510 CONFLICTS WITH OTHER CIRCUIT COURTS' DECISIONS THAT SECTION 510 MUST BE CONSTRUED BROADLY TO EFFECT ITS REMEDIAL PURPOSES.

A. The Fifth Circuit's Narrow Construction of "Any Right" in Section 510 Is Not Supported by Decisions of Other Circuits.

Congress enacted ERISA as a remedial statute to protect employees from retaliation and unlawful interference by employers with employee rights under benefit and pension plans. See 29 U.S.C. § 1001(b). Crucial to Congress's enactment is section 510. See Ingersoll-Rand Co. v. McClendon, __ U.S. __, 111 S.Ct. 478, 485, 112 L.Ed.2d 474, 486 (1990). However, the Fifth Circuit's narrow construction of section 510 removes from employees any ability to rely on a benefit plan provided by an employer. This construction undermines

the Congressional intent for ERISA's application to benefit plans and conflicts with decisions by other circuit courts. The Fifth Circuit's decision also has severe negative public policy consequences for coverage for all participants and beneficiaries in employer-sponsored insurance plans.

In affirming the district court's grant of summary judgment for the Company, the Fifth Circuit determined that McGann did not adduce evidence of the existence of "any right to which [he] may become entitled under the plan."[2] McGann v. H&H Music Co., 946 F.2d 401, 405 (5th Cir. 1991). In doing so, the court ruled that section 510's

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[2] The district court did not use this same ground as a basis for its decision; the Fifth Circuit noted that it did not rely on the district court's rationale in rendering its decision. McGann, 946 F.2d at 406 n.8.

prohibition against the interference with "any right" to which a participant or beneficiary "may become entitled" means that it is unlawful to interfere with any employee's right to receive "permanent" benefits under an ERISA plan. See id. at 405. Accordingly, in the Fifth Circuit's view, summary judgment for the defendants was appropriate.

> McGann's allegations show no promised benefit, for there is nothing to indicate that defendants ever promised that the $1,000,000 coverage limit was permanent. ... The continued availability of the $1,000,000 limit was not a right to which McGann may have become entitled for the purposes of section 510.

Id. (emphasis in original).[3]

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[3] As support for its conclusion, the Fifth Circuit defined the word "promised" used in this Court's recent decision, Ingersoll-Rand Co. v. McClendon, __ U.S. __, 111 S.Ct. 478, 485, 112 L.Ed.2d 474, 485-86 to mean "permanent." See McGann, 946 F.2d at 405. In Ingersoll-Rand, this Court held that ERISA preempts a state law claim for wrongful

(continued...)

1. The Fifth Circuit Misconstrued the Plain Language of Section 510.

The plain language of section 510, as well as conflicting decisions of other circuit courts, highlight a critical flaw in the Fifth Circuit's statutory interpretation. The language of section 510 is not confined to pension plans, to "vested" or "permanent" rights, or to plans that the employer has no discretion

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[3](...continued)
termination where the plaintiff alleges that his employment was terminated to prevent the vesting of pension benefits. __ U.S. at __, 111 S.Ct. at 485, 112 L.Ed.2d at 486. In so holding, the Court characterized section 510 as "crucial" to ERISA, pursuant to which a plaintiff may recover, inter alia, mental anguish and punitive damages. See id. at ___, 111 S.Ct. at 481, 484, 486, 112 L.Ed.2d at 482, 486, 488. While the Court noted that a claim like that advanced by McClendon was "prototypical" of the kind Congress intended to cover under Section 510," id. at ___, 111 S.Ct. at 486, 112 L.Ed.2d at 486, it did not require, or even imply, that "vested" or "permanent" benefits must be at issue for all section 510 claims.

to modify or terminate. Rather, the statute makes it unlawful for any "person" to take action against participants or beneficiaries for exercising rights under the provisions of any "employee benefit plan." See 29 U.S.C. § 1140. The statute also forbids actions against employees for the purpose of interfering with the attainment of "any right" to which an employee "may become entitled" under a "plan." Id.[4]

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[4] "[E]mployee benefit plan" and "plan" are defined under ERISA as follows:

> The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

29 U.S.C. § 1002(3). "[W]elfare benefit plan" is defined as:

> any plan, fund, or program ... established or maintained by an employer or by an employee organization, or by both, to the

(continued...)

In enacting ERISA, Congress explicitly intended to provide protection for employees. See 29 U.S.C. § 1001(a). This Court has affirmed ERISA's broad protective nature.[5] Moreover, because ERISA broadly preempts state laws, section 510 serves as a primary and critical enforcement mechanism to challenge actions that violate the statute's protective intent. See Ingersoll-Rand v. McClendon, __ U.S. at

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[4](...continued)
extent that such plan ... was established or is maintained for the purpose of providing ... through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness....

29 U.S.C. § 1002(1).

[5] See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983)("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.")

__ , 111 S.Ct. at 484-486, 112 L.Ed.2d at 485-88. The Fifth Circuit inappropriately narrowed the breadth of the statute by inserting the word "permanent" where it does not appear.

2. The Fifth Circuit's Decision Highlights A Conflict Among the Circuits.

The Fifth Circuit's restrictive construction of section 510 is at odds with decisions of other circuit courts that have applied the statute's language as written. McGann's petition to this Court should be granted so that this Court can effectuate Congress's intent to maintain uniformity in the application of this law. See Shaw v. Delta Airlines, 463 U.S. at 98-99.

Courts with which the Fifth Circuit is in conflict have ruled that section 510 encompasses claims that a defendant acted to prevent an employee from vesting in an

ERISA plan and claims that a defendant acted to interfere with an employee's ability to accrue additional benefits or to continue to participate in a plan. See Conkwright v. Westinghouse Elec. Co., 933 F.2d 231, 236-38 (4th Cir. 1991); Kross v. Western Elec. Co., 701 F.2d 1238, 1243 (7th Cir. 1983). See also Dister v. Continental Group, Inc., 859 F.2d 1108, 1111 (2d Cir. 1988); Zipf v. American Tel. & Tel. Co., 799 F.2d 889, 893 (3d Cir. 1986).[6]

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[6] Some district courts have set forth a narrow view of the scope of section 510, but petitioner submits that these cases, as well as the Fifth Circuit's decision, represent a misreading of the statute. See, e.g., Kelly v. Chase Manhattan Bank, 717 F. Supp. 227 (S.D.N.Y. 1989); Moehle v. NL Indus., Inc. 646 F. Supp. 769, 779 n.6 (E.D.Mo. 1986), aff'd, 845 F.2d 1027 (8th Cir. 1988); Donohue v. Custom Management Corp., 634 F. Supp. 1190, 1197 (W.D.Pa. 1986); Corum v. Farmer Credit Servs., 628 F. Supp. 707, 718 (D.Minn. 1986).

The Conkwright court specifically rejected the argument that section 510 applies only to those cases where an employee has been deprived of the right to "vest" in a benefit plan. It held that the statute extends to actions by "fully vested employees who claim denial not of their vested rights but of their ability to accrue additional benefits." 933 F.2d at 236. The Fourth Circuit reasoned that such a result is necessary to realize fully Congress's intent to protect employees with section 510.

> Extending § 510 to encompass claims brought by vested employees for denial of additional benefits comports with both the legislative language and the intent of Congress to give employees "broad remedies" for violations of pension rights. Section 510 prohibits an employer from discharging an employee "for the purpose of interfering with the attainment of any right to which such participant may become entitled" under a benefit plan. 29 U.S.C. § 1140 (emphasis added). Surely, Congress was not limiting § 510 only to those rights which a

> participant acquires upon vesting, or it easily could have referred to "vested rights." Similarly, the statute refers to rights to which a participant "may become entitled," which is to say that § 510 permits suits for interfering with rights not yet earned. We have no reason to constrict this "broad remedial" provision to only vested rights when the Act clearly contemplates suits to protect any rights implicated by employer action.

Id. at 237 (emphasis in original). Several district courts have also issued rulings consistent with this view. See, e.g., Nemeth v. Clark Equip. Co., 677 F. Supp. 899, 907-08 (W.D.Mich. 1987); Garry v. TRW, Inc., 603 F. Supp. 157 (N.D.Ohio 1985); Folz v. Marriott Corp., 594 F. Supp. 1007, 1014 (W.D.Mo. 1984).

Similarly, circuit courts have ruled that section 510 is violated if action is taken against an employee to interfere with continued medical coverage. See, e.g., Kross v. Western Elec. Co., Inc., 701 F.2d 1238. In Kross, the Seventh

Circuit found a cause of action under section 510 based on an allegation that the plaintiff's employment was terminated to prevent plaintiff's continued coverage under Western Electric's medical insurance plan. 701 F.2d at 1242-43. See also Fitzgerald v. Codex Corp., 882 F.2d 586 (1st Cir. 1989).

District courts also have construed section 510 to cover interference with an employee's continued medical coverage. See, e.g., Folz v. Marriott Corp., 594 F. Supp. 1007. In Folz, the court found liability under section 510 where an employer discharged an employee suffering from multiple sclerosis for the purpose of preventing the employee's further use of the employer's health insurance benefits. In finding for the plaintiff, the court held, relying on Kross, that "[t]he allegation that an employee was

discharged from his employment for the purpose of depriving him of continued participation in the employer's company-provided insurance program states a cognizable claim under § 510 of ERISA." 594 F. Supp. at 1014 (emphasis added). See also Vogel v. Independence Federal Savings Bank, 728 F. Supp. 1210 (D.Md. 1990).

Unlike the Fifth Circuit, the courts in the above cases determined the scope of section 510 by focusing on whether the employee was a participant or beneficiary in an extant plan at the time the employer took its adverse action. They did not read into the statute, as the Fifth Circuit has done, a notion that a benefit somehow must be "permanent." Under the reasoning of these courts, with which the Fifth Circuit is in conflict, McGann would have been able to maintain

his section 510 claim. It was undisputed that McGann was a participant and beneficiary of the Company's welfare benefit plan at the time the Company commenced its scheme to eliminate his medical coverage.

The Fifth Circuit's conflict with other circuit courts compels review by this Court. The Fifth Circuit's failure to explain how logically one may have a "right" under a plan if his or her employment is terminated but would not have such a "right" under the same plan if the plan is altered must be corrected. As discussed, infra, the distinction between plan modification and employment termination is an artificial one.

B. The Fifth Circuit's Narrow Interpretation of the Word "Discriminate" Removes Section 510 Protection from Employees When Alteration of the Plan Rather Than Termination of Employment Constitutes the Employer's Method of Retaliation or Interference.

In rejecting McGann's section 510 claim, the Fifth Circuit indicated its view that an employer may not terminate an employee to interfere with medical coverage but may effect that same purpose by altering the terms of a plan. See McGann, 946 F.2d at 405 n.7. Petitioner contends that if discrimination is not accorded its plain meaning as recognized by other circuit courts, section 510 will offer little protection to health plan participants and beneficiaries, contrary to Congress's intent.

In addition to holding that McGann lacked a "right" within section 510's meaning, the Fifth Circuit rejected

McGann's section 510 claim on the ground that Congress allowed employers the discretion to fashion the terms of welfare benefit plans and therefore could not have intended for the prohibition against discrimination to cover the instant circumstances. The court stated that "[t]o interpret 'discrimination' broadly to include defendants' conduct would clearly conflict with Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefit plans without governmental interference." Id. at 407. The Fifth Circuit's misreading of section 510 effectively removes any significance of the word "discriminate" which Congress deliberately included in the statute.

This rationale implicitly assumes that Congress did not intend the statutory

terms to be accorded their plain meaning, in light of the conflict that becomes readily apparent under the Fifth Circuit's reading of the statute. The court's interpretation suggests that Congress inadvertently rejected any limitation on an employer's discretion to alter a plan while incorporating section 510 to restrict an employer's ability to interfere with an employee's rights under a plan.

To the contrary of this interpretation, Congress expressly considered "the need for flexibility in rejecting the automatic vesting of welfare plans,"[7] yet included without modification the word "discriminate" and did not exempt any type of welfare benefit plan from section 510. Thus, the

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[7] See Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988).

legislative intent, as reflected in the statute's plain language, can only indicate that Congress did not intend for employers to have unchecked discretion with respect to setting the terms of welfare benefit plans.

When enacting remedial employment regulation, Congress has recognized repeatedly that such regulations necessarily restrict an employer's exercise of business judgment. See, e.g., Sure-Tan, Inc. v. NLRB, 467 U.S. 883 (1984); Textile Workers v. Darlington Mfg. Co., 380 U.S. 263, 269 (1965) (violation of NLRA for employer to shut down part of its business if anti-union animus played a part in the decision); Gavalik v. Continental Can Co., 812 F.2d 834, 847 (3d Cir.), cert. denied, 484

U.S. 979 (1987).[8] Here, contrary to the Fifth Circuit's reading of the statute, Congress explicitly limited the employer's discretion to alter the terms of welfare benefit plans by enacting section 510. McGann's claim is in step with such limitation, not in conflict with Congress's intent.

By holding that an employer violates section 510 only by discharging or otherwise disciplining a participant or beneficiary, the Fifth Circuit effectively reads the word "discriminate" out of section 510 as it applies to

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[8] "Just as Title VII does not guarantee employment, section 510 of ERISA does not guarantee [welfare plan] benefits; similarly, as Title VII prohibits discrimination on the basis of race with respect to such employment, so does section 510 prohibit discrimination with respect to [welfare plan] benefits...." Gavalik, 812 F.2d at 847 (quoting McLendon v. Continental Group Inc., 602 F. Supp. 1492, 1503-04 (D.N.J. 1985)).

welfare benefit plans.[9] By proposing the theory that employers are always permitted to alter the terms of welfare benefit plans, the Fifth Circuit ignores Congress's recognition that forms of "discrimination" exist distinct from termination.

Thus, the Fifth Circuit's overly zealous protection of the employer's discretion to change its plan removes the very protection section 510 gives employees. If an employee cannot expect to be treated in a non-discriminatory manner with respect to an insurance policy's lifetime cap simply because the contents of plan terms may be subject to

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[9] The Fifth Circuit acknowledged a number of decisions that recognized section 510 as a cause of action for wrongful termination claims. See McGann, 946 F.2d at 405 n.7, 406. It distinguished them, however, by stating only that the cases were not relevant because they involved "wrongful termination claims brought under section 510." Id.

change at the employer's whim, then section 510 of ERISA is an empty letter when welfare benefit plans are at issue. Congress could not have intended a construction of its statute that would rob its carefully chosen words of their meaning.

POINT II

THE FIFTH CIRCUIT HAS CREATED A UNIQUE AND OVERLY BURDENSOME STANDARD OF PROOF FOR PLAINTIFFS IN SECTION 510 CASES.

The Fifth Circuit "assume[d] that discovery of McGann's condition--and realization of the attendant, long-term costs of caring for McGann--did in fact prompt defendants to reconsider the $1,000,000 limit with respect to AIDS-related expenses to reduce the limit for future such expenses to $5,000."[10]

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[10] The Fifth Circuit also "assume[d] that there was a connection between the benefits reduction and either McGann's filing of claims or his revelations about (continued...)

McGann, 946 F.2d at 405 n.6. According to the court, however, summary judgment was appropriate because McGann allegedly "d[id] not challenge defendants' assertion that their purpose in reducing AIDS benefits was to reduce costs." Id. at 404-05. This ruling effectively elevates a general assertion of cost-savings to an absolute defense, even in those situations where an employer intentionally ties the cost-savings measures to one individual[11] or similarly-situated individuals.

The Fifth Circuit is at odds with other circuits and district courts which

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[10](...continued)
his illness," 946 F.2d at 404, and further "that the defendants knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses...." Id. at 404 n.4.

[11] The Fifth Circuit assumed that "McGann was the only plan beneficiary then known to have AIDS." 946 F.2d at 404 n.4.

have held that evidence of cost-savings supports, rather than refutes, a section 510 claim. See, e.g., Gavalik v. Continental Can Co., 812 F.2d at 857 n.39 ("[s]ection 510's essential purpose is to prevent employers from intentionally interfering with impending pension eligibility whether motivated by malice toward the particular employee(s) or by a general concern for the economic stability of the company); Reichman v. Bonsignore, Brignati & Mazzotta P.C., 818 F.2d 278, 281 (2d Cir. 1987) (evidence of $60,000 in cost-savings supports finding of unlawful motivation under section 510). See also, e.g., Folz v. Marriott Corp., 594 F. Supp. at 1015-16 (violation of section 510 where, inter alia, there was a "substantial economic incentive" for defendant to discharge plaintiff, i.e., the savings of payments from

defendant's self-funded medical, disability and salary continuation plans).

The Fifth Circuit's rationale also conflicts with rulings of other circuits on the use of circumstantial evidence to show discrimination. While citing cases which have held that a section 510 plaintiff must prove a defendant's "specific discriminatory intent as an essential element" of the claim, McGann, 946 F.2d at 404,[12] the Fifth Circuit disregarded the critical reasoning underlying those holdings. A plaintiff may prove "specific intent" with circumstantial evidence, and such intent

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[12] Kimbro v. Atlantic Richfield Co., 889 F.2d 869, 881 (9th Cir. 1989), cert. denied, __ U.S.__, 111 S.Ct. 53, 112 L.Ed.2d 28 (1990); Clark v. Resistoflex Co., a Div. of Unidynamics Corp., 854 F.2d 762, 770 (5th Cir. 1988); Dister v. Continental Group Inc., 859 F.2d at 1111; Gavalik v. Continental Can Co., 812 F.2d at 851.

is proved if it was "a motivating factor" in the defendant's decision to act. Id. at 404 n.4 (emphasis added). As noted, the Fifth Circuit assumed that the discovery of McGann's illness and McGann's filing claims prompted the Company's acts to effectuate a cutoff of McGann's right to make additional claims under the existing policy. Under the rationale controlling those decisions with which the Fifth Circuit is in conflict, McGann adduced sufficient evidence to allow a reasonable fact finder to find a section 510 violation.[13]

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[13] Nor, as the Fifth Circuit found, did the Company's intent become any less invidious or "specific" merely because the acts it directed at McGann also may have affected other persons similarly-situated or potentially similarly-situated to McGann. McGann, 946 F.2d at 404-06. No court has ever ruled that a law is violated only when a single person is affected by a defendant's discriminatory act. Cf. Personnel Administrator of Mass. v. Feeney, 442 (continued...)

POINT III

IMPORTANT PUBLIC POLICY REASONS EXIST FOR GRANTING THE PETITION.

By rejecting a section 510 cause of action against an employer who altered a plan to cut coverage of only one disease, the Fifth Circuit undermined the security of all ill or potentially-ill employees. The court's decision effectively encourages employers to discriminate against one employee or one class of employees solely on the basis of the class members' particular disease and

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[13](...continued)
U.S. 256, 277-79 (1979) ("Invidious discrimination does not become less so because the discrimination accomplished is of a lesser magnitude. Discriminatory intent is simply not amenable to calibration.... 'Discriminatory purpose,' however, implies more than intent as volition or intent as awareness of consequences. It implies that the decision maker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group.").

resulting need for the benefits. The Company's institution of an AIDS-related coverage cap reflects the unconscionable notion that only employees with "acceptable" diseases may have access to employer-provided health benefits. Nowhere within ERISA did Congress sanction such a concept.

The Fifth Circuit's narrowing of the scope of section 510 for employees, and the consequential expansion of employers' discretion under ERISA, threatens to worsen the current national crisis in health care. Not only does the decision undercut ERISA's broad protection to employees originally intended by Congress, see 29 U.S.C. § 1001(a), but it also endangers the security of the insurance package of any employee who is similarly-situated to all other employees

except for the specific disease he or she happens to contract.

The Fifth Circuit's decision takes away the security that Congress gave to employees with ERISA. Congress provided for "remedies, sanctions, and ready access to the Federal courts," 29 U.S.C. § 1001(b), because it found

> that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; ... that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; ... that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits ... and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

29 U.S.C. § 1001(a) (emphasis added).

Although the immediate crisis precipitating ERISA's enactment in 1974 concerned pension plans, Congress recognized the importance of regulating all types of employee benefit plans, including those that provide medical coverage or other benefits related to sickness and disability. 29 U.S.C. § 1002(1). The Fifth Circuit's suggestion that an employer has unchecked freedom to change its welfare benefits plan eviscerates ERISA's anti-discrimination cause of action. See McGann, 946 F.2d at 406-07.

The Fifth Circuit also accepted the Company's assertion that AIDS care was simply too expensive to be included in the Company's benefits package despite the fact that discriminatory intent clearly was underlying the decision. See id. at 404. In fact, in comparison to

other chronic conditions, AIDS care is not especially expensive.[14] Other options, such as reducing the level of coverage under a lifetime cap for all employees, could have accomplished the Company's cost-savings goal equally well. Rather, the Company chose to maintain lifetime coverage of up to $1 million for any medical care, so long as that care is

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[14] The average lifetime cost of HIV disease, from initial infection to death, is $85,000. Cost of AIDS Care in U.S. Is Seen at $5.8 Billion in '91, N.Y. Times, June 20, 1991, at A16 (reporting study by Dr. Fred J. Hellinger, Agency for Health Care Policy and Research, United States Department of Health and Human Services).

According to estimates from the mid-1980's, one case of end-stage kidney disease costs, on average, $158,000; paraplegia from an automobile crash costs an average of $68,700; and myocardial infarction costs an average of $66,800. Fox & Thomas, AIDS Cost Analysis and Social Policy, 15 Law, Med. & Health Care 186, Appendix Table 7 (Winter 1987/88), cited in Leonard, AIDS, Employment and Unemployment, 49 Ohio St. L.J. 929, 959 n.220 (1989). See also Pascal, The Costs of Treating AIDS Under Medicaid 1986-1991 23 (Rand Corporation 1987).

not related to the human immunodeficiency virus (HIV). That coverage was cut only for AIDS-related care illustrates the invidious prejudice of the Company against McGann and members of groups at greatest risk of contracting HIV.

Section 510 is a critical enforcement mechanism in circumstances such as those of McGann. It is especially necessary to counter discrimination where that discrimination is driven by unfounded and irrational fears associated with an "unpopular" disease such as AIDS.

In addition to removing protection from vulnerable individuals who suffer from specific diseases, the Fifth Circuit's decision further weakens the precarious position of employees covered under any health care insurance plan. The threat implicit in the Fifth Circuit's decision extends beyond the

membership of particular groups who, at least for the time being, are likely to lose benefits. The ultimate effect of this decision is to render insecure **any** employee's ability to rely on continued coverage once he or she makes a claim.

According to the Fifth Circuit, insurance providers, such as the Company, may freely offer cost reduction as the driving rationale for excising AIDS-related expenses from catastrophic illness coverage. Following this reasoning, they must also be free to restrict coverage of heart disease, Alzheimer's disease, particular types of cancer, or any other illness that may "cost too much." The Fifth Circuit's interpretation secures for employers an unrestricted ability to choose not only which benefits to offer but also which diseases and individuals "deserve"

coverage and which do not, even in response to one employee's submission of claim forms.

As a result of this Court's broad interpretation of ERISA's preemptive powers, see Shaw v. Delta Airlines, Inc., 463 U.S. 85, ERISA remains as virtually the only protection for employees under covered insurance plans. The Fifth Circuit's sanctioning the removal of one disease from a benefits package following an employee's filing of a claim not only leaves vulnerable those with AIDS and other catastrophic illnesses but also transforms ERISA's existing guardianship powers to an empty promise of protection.

Moreover, the Fifth Circuit's decision signals employers that they may shift to self-insured plans to avoid paying for particular diseases. Employers already seek to evade even minimal regulations

that states impose on commercial insurance by switching from traditional group health plans to self-insured arrangements.[15] The decision thus presents an especially grave danger to the possibility of non-discriminatory medical care coverage. It will open the floodgates for employers to leave state regulation behind and seek comfort in the ability to promise employees the world in benefits and deliver on nothing.

As a consequence of the high level of employer cutbacks in benefits and other employment perquisites, most employees are already vulnerable to unmanageable health care expenses and limited

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[15] Self-insured plans encompass more than half of all workers, as well as their spouses and dependents, amounting to over half of the population of the United States. Pear, Court Approves Cuts in Benefits in Costly Illness, N.Y. Times, Nov. 27, 1991, at A1, col. 2 (citing a report by the Health Insurance Association of America).

insurance coverage.[16] Employers are aware that in light of currently high unemployment rates, their offers of health benefits inhibit many employees from changing jobs or challenging benefits decisions.[17] A crisis exists

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[16] [Health care] cost increases have threatened the stability of the entire system.... In the face of massive cost increases, insurer and employer interest in 'cost containment' has, in part, shifted from pooling and insurance arrangements ... to patient and provider behavior ... and, above all, to 'cost-shifting' to those who use health care services.

Padgug & Oppenheimer, AIDS, Health Insurance, and the Crisis of Community, 5 Notre Dame J. L. Ethics & Pub. Pol'y 35, 39 (1990) (Padgug & Oppenheimer). See N.Y. Times, May 1, 1991, at D23 ("[S]o far it is the workers more than the corporations who are largely footing the mounting health care bills, data show.").

[17] Wasik, Special Report: The Crisis in Health Insurance, Consumers Digest 49, 53 (Aug. 1991)(An estimated 15 to 20 million Americans are refusing to change jobs for fear of losing health benefits.). See also N.Y. Times, Apr. 28, 1991, at A1 (This phenomenon, commonly known as "job lock," is spreading rapidly throughout the United States.).

in medical coverage not only for the 37 million Americans who lack any form of health insurance[18] but also for the large numbers of Americans with inadequate coverage.[19] Under the health insurance system currently in place in the United States, it not only violates ERISA but also is unconscionable to enable employers to circumscribe from an

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[18] Aukerman, Access to Health Care for the Uninsured: The Perspective of the American Academy of Family Physicians, 265 J. A.M.A. 2856 (June 5, 1991).

[19] Several million additional Americans are seriously underinsured. A 1985 estimate from data projected by the 1977 National Health Care Expenditures Study indicated that 26% of the non-elderly population, or approximately 56 million people in 1984, were "inadequately protected against the possibility of large medical bills." That number has increased steadily over the past fifteen years. Friedman, The Uninsured: From Dilemma to Crisis, 265 J. A.M.A. 2491, 2492 (May 15, 1991). Moreover, "within the next three years, more than one out of every four Americans are likely to find themselves uninsured for a significant period of time." Washington Post, June 3, 1991, at A9.

insurance plan those who have sought or may seek reimbursement for certain diseases as provided under their employer's medical insurance plan. The decision's consequences are especially stark in light of the circumstances of McGann who was as much in need of coverage as other individuals with similarly catastrophic and potentially more costly diseases. The Fifth Circuit's decision both underscores and enhances the vulnerability of this sector.[20]

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[20] See Washington Post, Jan. 6, 1991, at H11 ("employers are switching to self-insurance and then capping benefits for AIDS and related ailments at a fraction of what is allowed for other physical illness"); Padgug & Oppenheimer at 41 ("insurers or self-insured groups have attempted to impose unrealistically low caps on payments for AIDS or for AIDS-related drug therapies, caps that have not been used for any other major disease"); L.A. Times, June 9, 1991, at D7 ("many self-insured firms continue to limit or exclude coverage for AIDS, gay advocates say").

CONCLUSION

Because the Fifth Circuit's narrow interpretation of the reach of section 510 of ERISA conflicts with the plain language of the statute, Congress's intent and other circuits' interpretations, and because it threatens access to health care for the most vulnerable set of insured Americans who are already facing a crisis in medical coverage, we respectfully submit that

this Court grant petitioner's request for a writ of certiorari.

Dated: February 3, 1992
New York, New York

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APPENDIX

John MCGANN, Plaintiff-Appellant

v.

H & H MUSIC COMPANY, et al.,

Defendants-Appellees.

No. 90-2672.

United States Court of Appeals

Fifth Circuit

Nov. 4, 1991

Appeal from the United States District Court for the Southern District of Texas.

Before GARWOOD, JONES, and BARKSDALE, Circuit Judges.

GARWOOD, Circuit Judge:

Plaintiff-appellant John McGann (McGann) filed this suit under section 510 of the Employee Retirement Income Security Act of 1974, Pub.L. No. 93-406, 88 Stat. 832 (29 U.S.C. §§1001-1461) (ERISA) against defendants-appellees H & H Music Company

(H & H Music), Brook Mays Music Company (Brook Mays) and General American Life Insurance Company (General American) (collectively defendants) claiming that they discriminated against McGann, an employee of H & H Music, by reducing benefits available to H & H Music's group medical beneficiaries for treatment for acquired immune deficiency syndrome (AIDS) and related illnesses. The district court granted defendants' motion for summary judgment on the ground that an employer has an absolute right to alter the terms of medical coverage available to plan beneficiaries. 742 F.Supp. 392. We affirm.

FACTS AND PROCEEDINGS BELOW

McGann, an employee of H & H Music, discovered that he was afflicted with AIDS in December 1987. Soon thereafter,

McGann submitted his first claims for reimbursement under H & H Music's group medical plan, provided through Brook Mays, the plan administrator, and issued by General American, his plan insurer, and informed his employer that he had AIDS. McGann met with officials of H & H Music in March 1988, at which time they discussed McGann's illness. Before the change in the terms of the plan, it provided for lifetime medical benefits of up to $1,000,000 to all employees.

In July 1988, H & H Music informed its employees that, effective August 1, 1988, changes would be made in their medical coverage. These changes included, but were not limited to, limitation of benefits payable for AIDS-related claims

to a lifetime maximum of $5,000.[21] No limitation was placed on any other catastrophic illness. H & H Music became self-insured under the new plan and General American became the plan's administrator. By January 1990, McGann had exhausted the $5,000 limit on coverage for his illness.

In August 1989, McGann sued H & H Music, Brook Mays and General American under section 510 of ERISA, which provides, in part, as follows:

"It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a

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[21] Other changes included increased individual and family deductibles, elimination of coverage for chemical dependency treatment, adoption of a preferred provider plan and increased contribution requirements.

participant or beneficiary for exercising any right to which he is entitled under the provision of an employee benefit plan, ... or for the purpose of interfering with the attainment of any right to which such a participant may become entitled under the plan..." 29 U.S.C. §1140.

McGann claimed that defendants discriminated against him in violation of both prohibitions of section 510.[22] He claimed that the provision limiting coverage for AIDS-related expenses was directed specifically at him in retaliation for exercising his rights under the medical plan and for the

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[22] McGann also asserted various state law claims which the district court dismissed without discussion. McGann's brief in this court states that he "does not appeal from that part of the [district] court's order."

purpose of interfering with his attainment of a right to which he may become entitled under the plan.

Defendants, conceding the factual allegations of McGann's complaint, moved for summary judgment.[23] These factual allegations include no assertion that the reduction of AIDS benefits was intended to deny benefits to McGann for any reason which would not be applicable to other beneficiaries who might then or thereafter have AIDS, but rather that the reduction was prompted by the knowledge of McGann's illness, and that McGann was

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[23] General American claimed that the district court should have dismissed it as a defendant with respect to McGann's ERISA claim because ERISA does not create a cause of action against a nonemployer and McGann has never been employed by General American. Because of our disposition of this appeal on alternative grounds, we do not find it necessary to address this issue.

the only beneficiary then known to have AIDS.[24] On June 26, 1990, the district court granted defendants' motion on the ground that they had an absolute right to alter the terms of the plan, regardless of their intent in making the alterations. The district court also held that even if the issue of discriminatory motive were relevant, summary judgment would still be proper because the defendants' motive was to ensure the future existence of the plan and not specifically to retaliate against McGann or to interfere with his exercise of future rights under the plan.

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[24] We assume, for purposes of this appeal that the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses, that this knowledge was obtained either through McGann's filing of claims or his meetings with defendants, and that McGann was the only plan beneficiary then known to have AIDS.

DISCUSSION

[1] McGann contends that defendants violated both clauses of section 501 by discriminating against him for two purposes: (1) "for exercising any right to which [the beneficiary] is entitled," and (2) "for the purpose of interfering with the attainment of any right to which such participant may become entitled" In order to preclude summary judgment in defendants' favor, McGann must make a showing sufficient to establish the existence of a genuine issue of material fact with respect to each material element on which he would carry the burden of proof at trial. Celotex Corp. v. Catrett, 477 U.S. 317, 106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986).

[2] At trial, McGann would bear the burden of proving the existence of

defendants' specific discriminatory intent as an essential element of either of his claims. Kimbro v. Atlantic Richfield Co., 889 F.2d 869, 881 (9th Cir. 1989) (employee must prove employer's specific intent to retaliate for employee's exercise of rights under plan), cert. denied, ___ U.S. ___, 111 S.Ct. 53, 112 L.Ed.2d 28 (1990); Clark v. Resistoflex Co., a Div. of Unidynamics Corp., 854 F.2d 762, 770 (5th Cir. 1988) (employee must prove specific intent to interfere with employee's pension rights); Dister v. Continental Group, Inc., 859 F.2d 1108, 1111 (2d Cir. 1988) (section 510 claimant must prove specific intent to engage in activity prohibited by section 510); Gavalik v. Continental Can Co., 812 F.2d 834, 851 (3d Cir.) (claimant must prove specific intent to violate ERISA), cert. denied, 484 U.S.

979, 108 S.Ct. 495, 98 L.Ed.2d (1987). Thus, in order to survive summary judgment McGann must make a showing sufficient to establish that a genuine issue exists as to defendants' specific intent to retaliate against McGann for filing claims for AIDS-related treatment or to interfere with McGann's attainment of any right to which he may have become entitled.

[3] Although we assume there was a connection between the benefits reduction and either McGann's filing of claims or his revelations about his illness, there is nothing in the record to suggest that defendants' motivation was other than as they asserted, namely to avoid the expense of paying for AIDS treatment (if not, indeed, also for other treatment), no more for McGann than for any other

present or future plan beneficiary who might suffer from AIDS. McGann concedes that the reduction in AIDS benefits will apply equally to all employees filing AIDS-related claims and that the effect of the reduction will not necessarily be felt only by him. He fails to allege that the coverage reduction was otherwise specifically intended to deny him particularly medical coverage except "in effect." He does not challenge defendants' assertion that their purpose in reducing AIDS benefits was to reduce costs.

[4] Furthermore, McGann has failed to adduce evidence of the existence of "any right to which [he] may become entitled under the plan." The right referred to in the second clause of section 510 is not simply any right to which an employee

may conceivably become entitled, but rather any right to which an employee may become entitled pursuant to an existing, enforceable obligation assumed by the employer. "Congress viewed [section 510] as a crucial part of ERISA because, without it, employers would be able to circumvent the provision of promised benefits." Ingersoll-Rand Co. v. McClendon, ___ U.S. ___, 111 S.Ct. 478, 485, 112 L.Ed.2d 474 (1990) (emphasis added.

McGann's allegations show no promised benefit, for there is nothing to indicate that defendants ever promised that the $1,000,000 coverage limit was permanent. The H & H Music plan expressly provides: "Termination or Amendment of Plan: The Plan Sponsor may terminate or amend the Plan at any time or terminate any benefit

under the Plan at any time." There is no allegation or evidence that any oral or written representations were made to McGann that the $1,000,000 coverage limit would never be lowered. Defendants broke no promise to McGann. The continued availability of the $1,000,000 limit was not a right to which McGann may have become entitled for the purposes of section 510.[25] To adopt McGann's contrary construction of this portion of section 510 would mean that an employer could not effectively reserve the right to amend a medical plan to reduce benefits respecting subsequently incurred medical expenses, as H & H Music did here, because such an amendment would

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[25] McGann does not claim that he was not fully reimbursed for all claimed medical expenses incurred on or prior to August 1, 1988; or that the full $5,000 has not been made available to him in respect to AIDS related medical expenses incurred by him on or after July 1, 1988.

obviously have as a purpose preventing participants from attaining the right to such future benefits as they otherwise might do under the existing plan absent the amendment. But this is plainly not the law, and ERISA does not require such "vesting" of the right to a continued level of the same medical benefits once those are ever included in a welfare plan. See Moore v. Metropolitan Life Insurance Co., 856 F.2d 488, 492 (2d Cir. 1988).

McGann appears to contend that the reduction in AIDS benefits alone supports an inference of specific intent to retaliate against him or to interfere with his future exercise of rights under the plan. McGann characterizes as evidence of an individualized intent to discriminate the fact that AIDS was the

only catastrophic illness to which the $5,000 limit was applied and the fact that McGann was the only employee known to have AIDS. He contends that if defendants reduced AIDS coverage cause they learned of McGann's illness through is exercising of his rights under the plan by filing claims, the coverage reduction therefore could be "retaliation" for McGann's filing of the claims.[26] Under McGann's theory, any reduction in employee benefits would be impermissibly discriminatory if motivated by a desire to avoid the anticipated costs of continuing to provide coverage for a particular beneficiary. McGann

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[26] We assume that discovery of McGann's condition-and realization of the attendant, long-term costs of caring for McGann-did in fact prompt defendants to reconsider the $1,000,000 limit with respect to AIDS-related expenses and to reduce the limit for future such expenses to $5,000.

would find an implied promise not to discriminate for this purpose; it is the breaking of this promise that McGann appears to contend constitutes interference with a future entitlement.

McGann cites only one case in which a court has ruled that a change in the terms and conditions of an employee-benefits plan could constitute illegal discrimination under section 510.[27] Vogel v. Independence Federal Sav. Bank, 728 F.Supp. 1210 (D.Md. 1990). In Vogel,

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[27] Additionally, McGann relies on three cases involving wrongful termination claims brought under section 510. Fitzgerald v. Codex Corp., 882 F.2d 586 (1st Cir. 1989); Kross v. Western Electric Co.,701 F.2d 1238 (7th Cir. 1983); Folz v. Marriott Corp., 594 F.Supp. 1007 (W.D.Mo. 1984). In none of these cases, however, did the employer alter the terms or conditions of the plan at issue. Nor did any one of the three suggest that the changing of the terms of the plan might constitute a violation of section 510.

however, the plan change at issue resulted in the plaintiff and only the plaintiff being excluded from coverage. McGann asserts that the Vogel court rejected the defendant's contention that mere termination of benefits could not constitute unlawful discrimination under section 510, but in fact the court rejected this claim not because it found that mere termination of coverage could constitute discrimination under section 510, but rather because the termination at issue affected only the beneficiary. Id. at 1225. Nothing in Vogel suggests that the change there had the potential to then or thereafter exclude any present or possible future plan beneficiary other than the plaintiff. Vogel therefore provides no support for the proposition that the alteration or termination of a medical plan could alone sustain a

section 510 claim. Without necessarily approving of the holding in Vogel, we note that it is inapplicable to the instant case. The post-August 1, 1988 $5,000 AIDS coverage limit applies to any and all employees.[28]

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[28] As noted, the district court stated as one ground for its decision that an employer has an absolute right to alter the terms of an employee benefits plan, barring contractual provisions to the contrary. See Deeming v. American Standard, Inc., 905 F.2d 1124, 1127 (7th Cir. 1990) ("allegation that the employer-employee relationship, and not merely the pension plan, was changed in some discriminatory or wrongful way" is "a fundamental prerequisite to a §510 action"); Owens v. Storehouse, Inc., No. 1:90-CV-2292-JOF, slip op. at 4, ___ F.Supp. ___, ___ (N.D.Ga., June 28, 1991) (relying on Deeming in rejecting claim that employer violated section 510 by reducing AIDS benefits from $1,000,000 to $25,000 under employee health plan on ground that "§510 was designed to protect the 'employment relationship,' not the integrity of specific plans.") We do not find it necessary to decide this question.

McGann effectively contends that section 510 was intended to prohibit any discrimination in the alteration of an employee benefits plan that results in an identifiable employee or group of employees being treated differently from other employees. The First Circuit rejected a somewhat similar contention in Aronson v. Servus Rubber, Div. of Chromalloy, 730 F.2d 12 (1st Cir.), cert. denied, 469 U.S. 1017, 105 S.Ct. 431, 83 L.Ed.2d 357 (1984). In Aronson, an employer eliminated a profit sharing plan with respect to employees at only one of two plants. The disenfranchised employees sued their employer under section 510, claiming that partial termination of the plan with respect to employees at one plant and not at the other constituted illegal discrimination.

The court rejected the employees' discrimination claim, stating in part:

"[Section 510] relates to discriminatory conduct directed against individuals, not to actions involving the plan in general. The problem is with the word 'discriminate.' An overly literal interpretation of this section would make illegal any partial termination, since such terminations obviously interfere with the attainment of benefits by the terminated group, and, indeed, are expressly intended so to interfere.... This is not to say that a good plan could not be discriminatorily modified, intentionally benefitting, or injuring, certain identified employees or a certain group of employees, but a partial termination cannot constitute

discrimination per se. A termination that cuts along independently established lines-here separate divisions-and that has a readily apparent business justification, demonstrates no invidious intent." Id. at 16 (citation omitted).

The Supreme Court has observed in dictum: "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 103 S.Ct. 2890, 2897, 77 L.Ed.2d 490 (1983). See also Sejman v. Warner-Lambert Co., 889 F.2d 1346, 1348-49 (4th Cir. 1989), cert. denied, ___U.S.___, 111 S.Ct. 43, 112 L.Ed.2d 19 (1990); Young v. Standard Oil (Indiana), 849 F.2d 1039, 1045 (7th

Cir.), cert. denied, 488 U.S. 981, 109 S.Ct. 529, 102 L.Ed.2d 561 (1988); Phillips v. Amoco Oil Co., 799 F.2d 1464, 1471 (11th Cir. 1986), cert. denied, 481 U.S. 1016, 107 S.Ct. 1893, 95 L.Ed.2d 500 (1987); Hamilton v. Travelers Ins. Co., 752 F.2d 1350, 1351-52 (8th Cir. 1985); Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees, 740, F.2d 454, 456 (6th Cir. 1984) (Reynolds Metals), cert. denied, 469 U.S. 1109, 105 S.Ct. 786, 83 L.Ed.2d 780 (1985). To interpret "discrimination" broadly to include defendants' conduct would clearly conflict with Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefits plans without governmental interference.

The Sixth Circuit, in rejecting a challenge to an employer's freedom to choose the terms of its employee pension plan stated that "[i]n enacting ERISA, Congress continued its reliance on voluntary action by employers by granting substantial tax advantages for the creation of qualified retirement programs. Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide. In particular, courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation. Absent a violation of federal or state law, a federal court may not modify a

substantive provision of a pension plan." Id. (citation omitted) (emphasis in original).

The Sixth Circuit has subsequently declared that "the principle articulated in [Reynolds Metals] applies with at least as much force to welfare plans..." Musto v. American General Corp., 861 F.2d 897, 912 (6th Cir. 1988), cert. denied 490 U.S. 1020, 109 S.Ct. 1745, 104 L.Ed.2d 182 (1989).[29]

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[29] Musto involved an ERISA claim by retirees that their former employer violated contractual and fiduciary duties by changing the terms of their medical coverage. The court rejected plaintiffs' claim that they had a vested interest in the terms of their medical coverage. Musto, like Reynolds Metals, noted that "[t]here is a world of difference between administering a welfare plan in accordance with its terms and deciding what those terms are to be. A company acts as a fiduciary in performing the first task, but not the second." Id. at 911.

As persuasively explained by the Second Circuit, the policy of allowing employers freedom to amend or eliminate employee benefits is particularly compelling with respect to medical plans:

"With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. Automatic vesting was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the cost of treatment independent of inflation. These

unstable variables prevent accurate predictions of future needs and costs." Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2nd Cir. 1988) (Metropolitan Life).

In Metropolitan Life, the court rejected an ERISA claim by retirees that their employer could not change the level of their medical benefits without their consent. The court stated that limiting an employer's right to change medical plans increased the risk of "decreas[ing] protection for future employees and retirees." Id. at 492; see also Reynolds Metals, 740 F.2d at 457 ("judicial interference into the establishment of pension plan provisions...would serve only to discourage employers from creating voluntarily pension plans") (footnote omitted).

McGann's claim cannot be reconciled with the well-settled principle that Congress did not intend that ERISA circumscribe employer's control over the content of benefits plans they offered to their employees. McGann interprets section 510 to prevent an employer from reducing or eliminating coverage for a particular illness in response to the escalating costs of covering an employee suffering from that illness. Such an interpretation would, in effect, change the terms of H & H Music's plan. Instead of making the $1,000,000 limit available for medical expenses on an as-incurred basis only as long as the limit remained in effect, the policy would make the limit <u>permanently</u> available for all medical expenses as they might thereafter be incurred because of a single event, such as the contracting of AIDS itself.

Under McGann's theory, defendants would be effectively proscribed from reducing coverage for AIDS once McGann had contracted that illness and filed claims for AIDS-related expenses. If a federal court could prevent an employer from reducing an employee's coverage limits for AIDS treatment once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alternation or termination of ERISA plans would be sorely tested.

[5] As noted, McGann has failed to adduce any evidence of defendants' specific intent to engage in conduct proscribed by section 510. A party against whom summary judgment is ordered cannot raise a fact issue simply by stating a cause of action where defendants' state of mind is a material

element. Clark, 854 F.2d at 771. "'There must be some indication that he can produce the requisite quantum of evidence to enable him to reach the jury with his claim.'" Id. at 771 (quoting Hahn v. Sargent, 523 F.2d 461, 468 (1st Cir. 1975), cert. denied, 425 U.S. 904, 96 S.Ct. 1495, 47 L.Ed.2d 754 (1976)).

[6, 7] Proof of defendants' specific intent to discriminate among plan beneficiaries on grounds not proscribed by section 510 does not enable McGann to avoid summary judgment. ERISA does not broadly prevent an employer from "discriminating" in the creation, alteration or termination of employee benefits plans; thus, evidence of such intentional discrimination cannot along sustain a claim under section 510. That section does not prohibit welfare plan

discrimination between or among categories of diseases. Section 510 does not mandate that if some, or most, or virtually all catastrophic illnesses are covered, AIDS (or any other particular catastrophic illness) must be among them. It does not prohibit an employer from electing not to cover or continue to cover AIDS, while covering or continuing to cover other catastrophic illnesses, even though the employer's decision in this respect may stem from some "prejudice" against AIDS or its victims generally. The same, of course, is true of any other disease and its victims. That sort of "discrimination" is simply not addressed by section 510. Under section 510, the asserted discrimination is illegal only if it is motivated by a desire to retaliate against an employee or to deprive an employee of an existing

right to which he may become entitled. The district court's decision to grant summary judgment to defendants therefore was proper. Its judgment is accordingly

AFFIRMED.

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 90-2672

JOHN MCGANN,

Plaintiff-Appellant,

versus

H & H MUSIC COMPANY,

ET AL.,

Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Texas

Before GARWOOD, JONES and BARKSDALE, Circuit Judges

J U D G M E N T

This cause came on to be heard on the record on appeal and was argued by counsel.

ON CONSIDERATION THEREOF, It is now here ordered and adjudged by this Court that the judgment of the District Courtin this case is affirmed.

IT IS FURTHER ORDERED that plaintiff-appellant pay to defendants-appellees the costs on appeal to be taxed by the Clerk of this Court.

November 4, 1991

ISSUED AS MANDATE: November 26, 1991

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN MCGANN	§	
	§	
Plaintiff	§	
	§	CIVIL ACTION NO.
	§	H-89-1995
VS.	§	
	§	
H & H MUSIC COMPANY, et al.,	§	
	§	
	§	
Defendants.	§	

ORDER

Pending before the Court is a motion for summary judgment filed by Defendants H & H Music Company, Brook Mays Music Company and General American Life Insurance Company. After consideration of said motion and the response filed by Plaintiff John McGann, the Court is of the opinion that there is no genuine issue of material fact in this case, and that, for the reasons discussed below, Defendants' motion should be granted.

Statement of the Case

John McGann brought this claim of discrimination and violation of his rights under ERISA against his employer, H & H Music Company Brook Mays Music Company and the insurance company that administers his medical plan, General American Life Insurance Company. He alleges that because Defendants changed portions of the group medial care plan they violated ERISA, 29 U.S.C. §1001 et seq.

McGann began working for Defendant H & H Music Company in 1982. In December of 1987 he was diagnosed as having A.I.D.S. and informed Defendant of his diagnosis. In July of 1988 Defendants made changes in their health insurance program. Previously employees that were diagnosed with A.I.D.S. were entitled to maximum benefits of $1,000,000.00 during their

lifetime. The new plan decreased A.I.D.S. benefits to a maximum of $5,000.00 and also discontinued benefits for chemical dependency. In addition, in July 1988, the medical coverage changed from fully insured to self-insured. McGann after learning of the changes in the plan filed suit.

Summary Judgment

Summary judgment is authorized if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. The United States Supreme Court has interpreted this rule to mandate the entry of summary judgment after an adequate time for discovery against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party

will bear the burden of proof at trial. Celotex Corp. v. Catrett, 477 U.S. 317 (1986)

Discussion

The paramount purpose of ERISA is to protect the solvency of employee benefit plans to ensure that the valid claims of employees and their beneficiaries will be paid. Orchard Creek Hospital, et al. v. The Life Insurance Company of Virginia, et al., Cause No. H-88-3500 (S.D. Tex. March 1990). ERISA sets forth uniform standards dealing with reporting, disclosure and fiduciary responsibility. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 91 (1983). Furthermore, ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits. Id.

The purpose of the changes in the group medical plan made by Defendants jibe with the ultimate purpose of ERISA: protection of the plan. Defendants made changes in the plan because in past years the plan suffered serious financial losses. Defendants were faced with either dropping the plan altogether or making changes. The alterations were not made to discriminate against McGann or anyone who was diagnosed with A.I.D.S.

Defendants had the right to make changes in the plan and complied with the requirement of ERISA. According to ERISA every employer must provide its employees with a summary plan description ("SPD"). 29 U.S.C. §1022(a)(1). The SPD must be written in a manner calculated to be understood by the average plan participant. 29 U.S.C. §1022(a)(1). Defendants followed these ERISA

provisions and in the SPD they handed out to their employees they included a paragraph clearly stating that the plan sponsor could terminate or amend the Plan or terminate any benefit under the Plan at any time. Therefore, beneficiaries were put on notice that from year to year their group medical plan could change.

In a similar case an insurance company completely canceled a group plan and one of the beneficiaries filed suit against the insurance company in an attempt to force it to provide insurance benefits. Hamilton v. Travelers Ins. Co., 752 F.2d 1350 (8th Cir. 1985). The Court held that the insurance company had the right to terminate the plan. Id. The insurance company had complied with the ERISA requirements, and provided an SPD which was distributed to all employees. The SPD tracked the language of the

Defendants' SPD. The court in Hamilton held that neither the employer nor the insurance company was under any contractual obligation to refrain from terminating the plan. Id. at 1351. Furthermore, the Court found that ERISA does not create liability on the part of an employer who changes the kind of health plan it provides to its employees where no contract prohibits or prevents such change. Id. at 1352. The contract provided by Defendants in the case before this Court does not prohibit or prevent any changes from being made in the group plan. Just as the Defendants can make the benefits larger for A.I.D.S. patients they can also make the benefits smaller.

Finally, the Plaintiff claims that the motion for summary judgment should be denied because there is evidence of

discrimination. Although an analysis of Plaintiff's claim of discrimination is not necessary, even using this analysis Plaintiff's claim fails.

In a Third Circuit case the court set out three requirements to prove discrimination under ERISA. avalik v. Continental Can Co., [sic] 812 F.2d 834 (3rd Cir. 1987). An employee must demonstrate (1) prohibited employer conduct, (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled. Id. at 852. Plaintiff cannot prove that Defendants' conduct was prohibited. The Defendants had the right to change or terminate the medical plan under ERISA. In addition, the action was not taken to interfere with the rights of McGann but to ensure the future existence of the plan.

McGann was not entitled to health benefits whose terms never change. He was not denied any compensation for expenses related to treatment for A.I.D.S. during 1987 when the plan paid up to $1,000,000.00 for A.I.D.S. patients, nor was he denied medical compensation for insurance claims once Defendants changed the health plan in 1988. Therefore, McGann's claim of discrimination must fail.

Since Defendants have complied with the regulations of ERISA, legally have the right to make changes in its group medical plan and did not act in a discriminating manner Plaintiff's claim must fail.

For the reasons stated above, it is therefore

ORDERED that Defendants' motion for summary judgment is GRANTED.

Signed this 26th day of June, 1990 at Houston, Texas.

Norman W. Black
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF TEXAS

HOUSTON DIVISION

JOHN MCGANN	§	
	§	
Plaintiff	§	
	§	CIVIL ACTION
	§	NO. H-89-1995
	§	
VS.	§	
	§	
H & H MUSIC COMPANY, et al.,	§	
	§	
Defendants.	§	

FINAL JUDGMENT

The Court having granted Defendants' motion for summary judgment, this case is here DISMISSED with prejudice.

Signed, this 26th day of June, 1990 at Houston, Texas.

Norman W. Black
United States
District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN MCGANN,	]	
	]	CIVIL ACTION NO.
	]	H-89-1995
Plaintiff	]	
	]	
vs.	]	
	]	
H&H MUSIC COMPANY,	]	
BROOK MAYS MUSIC	]	
COMPANY, AND	]	
GENERAL AMERICAN	]	
LIFE INSURANCE	]	
COMPANY	]	
	]	
Defendants.	]	

ORDER GRANTING SUBSTITUTION OF PARTY

On this day came before the Court the Motion of **FRANK GREENBERG**, Independent Executor of the Estate of **JOHN W. "JACK" MCGANN**, Deceased, to substitute as a party to this proceeding for **JOHN MCGANN**, Plaintiff, Deceased, pursuant to Federal Rule of Civil Procedure 25 (a)(1). The Court having considered the motion, finds

that substitution is necessary and therefore it is hereby

ORDERED that **FRANK GREENBERG**, Independent Executor of the Estate of **JOHN W. "JACK" MCGANN**, is substituted for **JOHN MCGANN**, Deceased, as Plaintiff in this case.

Done this 27th day of January 1992.

Norman Black
U.S. District Judge

MAR 3 1992

No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

— v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MOTION AND BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION, AIDS ACTION COUNCIL, JESSICA DAVIS, M.D., GAY MEN'S HEALTH CRISIS, MICHIGAN ORGANIZATION FOR HUMAN RIGHTS, NATIONAL LEAGUE FOR NURSING, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS (ATLANTA CHAPTER), AND THE UNIVERSITY OF MICHIGAN PUBLIC HEALTH LAW CLINIC AS *AMICI CURIAE* IN SUPPORT OF PETITIONER.

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March 3, 1992

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No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

— v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF AS AMICI CURIAE

The American Public Health Association ("APHA"), AIDS Action Council, Jessica Davis, M.D., Gay Men's Health Crisis ("GMHC"), Michigan Organization for Human Rights ("MOHR"), National League for Nursing ("NLN"), National Association of People with AIDS ("NAPWA") (Atlanta chapter) and the University of Michigan Public Health Law Clinic, by their attorney, move this Court to grant them leave to file a brief in support of the Petition for Grant of Writ of Certiorari, and in support of this motion, show as follows:

1. The Defendants, H & H Music Company, Brook Mays Music Company, and General American Life Insurance Company,

have refused consent to the submission of this *amici curiae* brief.

2. Applicants' interest in the issues in, and the outcome of, this petition stems from their recognition that insurance caps in AIDS-related cases will harm the nation's already fragile health care system and will unfairly restrict AIDS patients' critical access to medically necessary treatments.

2. Applicants believe that a brief *amici curiae*, submitted by applicants, would be desirable in that the issues involved in this case concern not only the parties and applicants, but are also of considerable public interest and import, and it is therefore highly important that Petitioner's position be developed and presented fully.

Respectfully submitted,

David Picntkowsky
Counsel of Record
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Ann Arbor, Michigan
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(313) 764-6783

Attorney for Amici Curiae

DATED: Ann Arbor, Michigan
March 3, 1992

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici American Public Health Association, AIDS Action Countil, Jessica Davis, M.D., Gay Men's Health Crisis, Michigan Organization for Human Rights, National League for Nursing, National Association of People with AIDS (Atlanta Chapter), and the University of Michigan Public Health Law Clinic share a common professional opinion--that insurance benefit caps such as the one at issue in this case are contrary to the law, damaging to the nation's health care system, seriously detrimental to the people with HIV infection who are subject to them, inherently discriminatory, and based on misconceptions regarding the relative cost of caring for people with HIV disease.

Amici, who include some of the nation's leading experts in the area of

public health and social policy, as well as several of the leading providers of services to people with HIV infection, all have a strong interest in the outcome of this case and believe their views can be of special interest to the Court.

American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health and to disease protection. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialities in public health, including patients and health professionals such as physicians, nurses, health educators, and family planning specialists. APHA also publishes a technical

report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

AIDS Action Council, founded in 1983, is the only national organization devoted solely to the public policy issues presented by the AIDS crisis. The AIDS Action Council has established a coalition of national organizations representing the various constituencies affected by AIDS which meets monthly to review federal legislation and support appropriations that comprehensively address all AIDS-related issues.

Jessica Davis, M.D., is an associate professor of clinical pediatrics and genetics at Cornell

University Medical Center. She specializes in clinical genetics and chronic illnesses. Dr. Davis is a president of the Council of Regional Networks, a member of the Alliance of Medical Genetic Support Groups, College of Medical Genetics, and on the Medical Advisory Board of the National Mars An Association and Tay Sachs Association. Dr. Davis has treated a number of children with AIDS.

Gay Men's Health Crisis ("GMHC"), a New York not-for-profit corporation, is the nation's oldest and largest AIDS service and education organization. GMHC currently provides a range of support services to more than 4,500 clients with AIDS and HIV illness each year. Many of GMHC's clients remain able to

work despite their illness, and are dependent upon the health insurance they receive through their employment to afford medical care. These clients are among the individuals who would be damaged by policies, such as the respondents' in this case, that impose arbitrary caps upon the dollar amount of AIDS-related coverage that is provided. Through its Legal Services and Financial Advocacy programs, GMHC counsels and represents individuals who do not receive the health care or health insurance benefits to which they are entitled. Accordingly, GMHC has both an institutional interest and an interest on behalf of its clients in the outcome of this litigation.

Michigan Organization for Human Rights ("MOHR") is a statewide gay

and lesbian rights organization in Michigan. MOHR has a mailing list of over 13,000 people and has been involved in AIDS legal issues for the past eight years. MOHR has an AIDS advocacy program which has, over the past two years, focused on AIDS-related public policy issues.

National League for Nursing ("NLN"), which originated in 1893 as the American Society of Superintendents of Training Schools for Nurses, is a non-profit coalition of nurses, other health care professionals, and consumers working to improve the quality of health care. NLN pursues its quality mission as the national accrediting body for nursing education programs, and through consulation services, continuing education programs, test

services, research, publications, and lobbying efforts on behalf of nursing and consumers. NLN's subsidiary, the Community Health Accreditation Program, was recently recommended by the Health Care Financing Administration for "deemed status" as the nation's only independent accrediting body dedicated solely to elevating the quality of care in the home care and community health arenas.

National Association of People with AIDS ("NAPWA") (Atlanta Chapter) is the only membership coalition in the State of Georgia made up of people living with HIV infection. The mission of the volunteer-based organization, which has over 1,800 members, is to enhance the quality of life of HIV-affected individuals

through education, advocacy and community leadership. NAPWA's program focuses on providing treatment information and peer counseling, publication of a monthly newsletter and advocacy on behalf of people infected with HIV.

The University of Michigan Public Health Law Clinic is a clinical law program which, in the past three years, has had approximately 50 law students participate on AIDS legal issues. Under the direction of Professors David Chambers and David Piontkowsky, the students have drafted briefs, filed cases, and argued before federal and state courts on behalf of indigent clients with HIV. The Clinic has had AIDS-related issues as its focus for the past three years.

Amici submit this brief so that this Court will have available for its deliberations an accurate statement of the position of public health experts and AIDS service providers regarding the important issues presented by this appeal.

STATEMENT OF THE CASE

Amici rely on the Statement of the Case set out in Brief for Appellants.

SUMMARY OF THE ARGUMENT

The health care needs spawned by the AIDS crisis have three primary sources of funding: private insurance, Medicaid, and hospitals which provide uncompensated care. Medicaid and uncompensated care form the nation's health care "safety net". They exist essentially to fill a gap created by the inability of the private insurance industry to provide coverage for everyone. In other words, they represent a "last resort" in the health care financing process. Thus, from a public health perspective, private insurance represents the optimal choice for funding HIV/AIDS-related health care.

Two major reasons inform this conclusion. First, Medicaid reimbursements are far below those provided through private insurance. Consequently, the medical establishment has a financial incentive to minimize its treatment of Medicaid recipients. Secondly, uncompensated care provided by hospitals should be reserved for the truly indigent and uninsured. Current data reveals that the nation's AIDS population already depends heavily on the "safety net"

The Fifth Circuit's decision artificially expands the ranks of the uninsured; previously insured employees like John McGann are now forced to turn to the "safety net". Both the Medicaid program and the ability of the nation's hospitals to continue providing uncompensated care will be sorely tested.

Given the financial incentives for many employers to adopt McGann-like health benefit caps, the threat to an already overburdened health care system is very serious. Already, public hospitals that disproportionately bear the burden of treating indigent and uninsured persons with AIDS are suffering significant financial losses.

Unfortunately, amidst all this analysis of costs, the lower courts have lost sight of the fact that without adequate coverage for health care costs, HIV-infected persons cannot take advantage of medical treatments necessary to meaningfully extend their lives. The prophylatic use of AZT (to delay the onset of an extremely deadly form of pneumonia) is one such promising treatment. Of course, when an opportunistic disease does strike a person with HIV, the need for

protection from catastrophic health care costs becomes even greater.

Therefore, amici urge the Court to find that the caps on benefits enacted by H & H Music Company is a discriminatory practice, cruelly denies employee health benefits at a time when they ar most needed, do not represent a valid form of cost containment and should not be sheltered by ERISA.

ARGUMENT

IF PERMITTED TO CONTINUE, THE DISCRIMINATORY PRACTICES APPROVED BY THE FIFTH CIRCUIT'S DECISION WILL SUVERT THE CONGRESSIONAL INTENT, FURTHER JEOPARDIZE THE NATION'S ALREADY OVERBURDENED HEALTH CARE SYSTEM, AND ULTIMATELY, IMPEDE THE SURVIVABILITY OF HIV-INFECTED PERSONS.

A. Denial of promised job-derived health insurance benefits will force many HIV-infected persons to rely on the inferior health care financing alternative of Medicaid as well as pressure hospitals to

undertake even greater levels of uncompensated care.

In 1991, the National Commission on Acquired Immune Deficiency Syndrome reported that individuals with AIDS faced three primary options for funding their care: private insurance (through either a job-based or an individual policy), Medicaid, and good fortune. National Commission on Acquired Immune Deficiency Syndrome, America Living With AIDS 70 (1991) [hereinafter National AIDS Commission Report]. The final category encompasses the generosity of others upon which the nation's uninsured depend for their health care needs. An important component in this third category is the "uncompensated care" that both public and private hospitals provide to indigent patients.

In passing ERISA, Congress reocgnized that, from a public health perspective,

private insurance represents the optimal choice for funding HIV/AIDS-related care. Despite its virtues as the federal health insurance program for the poor, Medicaid does not match the financial reimbursement capabilities of the private insurance industry.

> [W]hile Medicaid is preferable to having no insurance at all, it differs from private insurance in certain critical ways that affect Medicaid recipients' access to care. In many states, Medicaid pays <u>much lower rates</u> to physicians than does private insurance. Chiefly for this reason, most office-based private physicians avoid or limit their acceptance of Medicaid recipients (emphasis added).

Jesse Green & Peter S. Arno, <u>The 'Medicaidization' of AIDS</u>, 264 JAMA 1261 (1990).

Medicaid's payment scheme in two cities with the highest concentration of persons with AIDS is fairly indicative of this dismal truth. "[P]hysicians are reimbursed by Medicaid an average of 33% of the rates paid by private insurance in

San Francisco and 15% in New York." Id. at 1264. The reality in health care financing is that Medicaid is simply not an adequate replacement for private insurance.

Moreover, Medicaid is intended to serve only the very poor in this country, rather than the larger pool of people who are without private insurance. "Although Medicaid is designed to cover low-income people, it falls short of serving the needs of many poor individuals because of the stringent criteria defining 'low-income' and the prerequisite that assets be below a certain minimum." National AIDS Commission Report, supra, at 73. Sadly, the segment of the AIDS population that is not protected from catastrophic health costs by either private insurance or public insurance is sizable:

approximately 29% of the nation's AIDS population is uninsured. Id. at 70.

To a significant extent, these uninsured persons with AIDS depend on the ability of the nation's hospital system to provide them with charge-free care. With the number of uninsured Americans growing and Medicaid's inability to provide reimbursements at market price, hospitals have responded to this aspect of the nation's health-care crisis by devoting ever-increasing resources toward the provision of uncompensated care. The statistics are startling. "In 1980, uncompensated care cost $3.5 billion, representing 4.6 percent of total costs. By 1986, the annual cost of uncompensated care had risen to $8.4 billion or 6.0 percent of total costs." American Hospital Association, AIDS/HIV Infection: Recommendations for Health Care Practices

and Public Policy 46 (1988) [hereinafter AHA Report]. While it does not purport to address the health care needs of all the nation's uninsured, nonetheless, hospital-provided uncompensated care, like Medicaid, remains an indispensable and permanent part of the nation's health care financing process.

Clearly, Medicaid and uncompensated care fill a gap created by the inability of the private insurance industry to provide coverage for everyone. Unfortunately, the Fifth Circuit's decision below expands this gap unnecessarily. As the nation's health care "safety net", Medicaid and uncompensated care is reserved for those persons for whom the private insurance alternative is truly unavailable. By revoking promised health benefits for a specific disease like HIV infection, self-

insured employers such as H & H Music Company artificially inject their employees into the ranks of the uninsured.

Given the costs associated with a catastrophic illness such as HIV infection, reliance on personal resources will be extremely difficult for most employees.[1] Without the protection of insurance and after expending personal resources, employees in the position that John McGann was placed necessarily will turn to Medicaid and uncompensated care to provide for their vital health care needs. The only remaining "option" would be to forgo the medical treatments necessary to combat HIV infection. By sanctioning

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[1]The latest study projects that treatment for a person with AIDS costs $32,000 per year and $85,133 per lifetime. The same study also estimates that medical care for an HIV-infected person without AIDS amounts to $5,150 per year. Fred J.Hellinger, Forecasting the Medical Care Costs of the HIV Epidemic: 1991-1994 Forecasts, 28 Inquiry 213, 219, 222-3 (1991) [hereinafter Hellinger 1991-1994 Forecasts].

employers who abandon their promise to provide for employee health care costs, the Fifth Circuit ultimately has shifted responsibility for much of the costs normally paid by insurance unto the public sector and public-minded hospitals. Such a shift augurs poorly for the health of health care in America.

B. This deterioration in HIV-related health care financing seriously threatens the integrity of the nation's health care "safety net".

The response of the nation's health care "safety net" to the HIV epidemic has been noticeably burdensome. From a disbursement perspective, Federal involvement has been substantial. "Medicaid is currently the most important source of financing for AIDS and HIV-related health care benefits." National AIDS Commission Report, supra, at 72. Approximately 40% of this nation's AIDS

population depend upon Medicaid to meet their AIDS-related health care expenses. Id. at 70. In light of the fact that in 1989 the Medicaid program covered less than one-tenth of the nation's total population that private insurance did,[2] it is clear that the demand on Medicaid to finance this care has been disproportionately large. More disturbingly, AIDS-related health care financing is in the midst of a transformation known as "Medicaidization". "The National Center for Health Statistics reports that the share of inpatient care for AIDS that is financed by public sources (primarily Medicaid) rose from 25% in the 1984-85 period to 41% in the 1986-87 period, while the private insurance

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[2]In 1989, Medicaid provided coverage for 7.4% of the nation, while private insurance reached 77.0%. Health Insurance Association of America, Source Book of Health Insurance Data 25, 25-6 (1991) [hereinafter 1991 HIAA Source Book].

share declined from 49% to 43%." Green & Arno, supra, at 1261.

In addition, AIDS experts have calculated that Medicaid funds the nation's AIDS-related care at a rate two and one-half times greater than it does so for the nation's health care needs overall.[3] Given that reality, the latest estimates suggest that Medicaid contributed $1.100 billion in 1991 toward addressing the costs of treating AIDS.[4] Furthermore, according to total AIDS care cost projections for 1992-94, the burden

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[3]"Medicaid pays for 11% of total health care costs in the United States. By contrast, the Health Care Financing Administration estimates that Medicaid funds 25% of AIDS care." Green and Arno, supra, at 1261. Since Medicaid reimbursements are not on-par with private insurance reimbursements, it is not surprising that while Medicaid covers 40% of the AIDS population, its share of AIDS care funding drops to 25%.

[4]The Division of Cost and Financing of the Department of Health and Human Services' Agency for Health Care Policy and Research estimates that nationally $4.398 billion was expended in 1991 toward the costs of treating people with AIDS. Hellinger 1991-1994 Forecasts, supra, at 223.

on Medicaid is expected to rise to $1.361 billion in 1992, $1,643 billion in 1993, and $1.965 billion in 1994.[5] The basic message emanating from these figures is that the federal government's Medicaid program can anticipate a significant increase, both in dollar value and percentage share terms, in the resources it must devote towards AIDS-related health care payments.

However, in these days of governmental red ink, the climate is ripe for retraction of the Medicaid budget. Medicaid benefit payments have mushroomed from $48.7 billion in 1988 to $54.5 billion in 1989 and $64.9 billion in 1990. 1991 HIAA Source Book, supra, at 43. This represents a growth in payments of 12.6% and 19.0%, respectively. One prominent

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[5]The corresponding projected total costs for AIDS treatment are $5.444 billion in 1992, $6.572 billion in 1993, and $7.859 billion in 1994. Id. at 223.

example of the clamor for fiscal belt-tightening in federal health expenditures lies in President Bush's recent proposal regarding the nation's health care crisis. The President's idea of utilizing tax credits and tax deductions to make health insurance accessible to the poor will have to be offset by some other component of the federal government's budget for health-related issues.

With administration cost estimates for the plan ranging from $55 to $100 billion over five years, "Members of Congress who have been briefed on the plan by Administration officials estimate that . . . 60 percent [of the money would come from] Medicaid." Robert Pear, Bush Health Plan would be Financed by Medicare Curb, N.Y. Times, Feb. 3, 1992, at A9, col. 4. In other words, the Medicaid budget must eliminate an average of $6.6 billion to

$12 billion per year in payments to fund the Bush plan. Irrespective of whether national health care reform actually occurs, the ability of Medicaid to satisfy the projected demand for AIDS-related disbursements will be subject to serious budgetary challenge. Thus, the additional demand on the Medicaid system that will be induced by discriminatory practices similar to those of H & H Music Company will further strain a public insurance system that can ill afford it.

Budgetary pressures notwithstanding, the Medicaid program is under court order to pay for a drug, zidovudine (also known as AZT or by the brand name Retrovir).[6] AZT is an antiretorvirus used by persons

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[6] "[Zidovudine] has been shown to be of clinical value and remains the foundation of all expected strategies for the treatment of HIV infection (emphasis added)." Paul A. Volberding, Recent Advances in the Medical Management of Early HIV Disease, 6 J. Gen. Internal Med. S7, S9 (Jan./Feb. 1991 Supp.).

with HIV to delay the onset of opportunistic diseases which occur if the HIV virus depletes the body's CD4 cells. In Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989), the Eighth Circuit upheld the lower court's decision in a class-action suit that mandated that the Missouri Medicaid program is "enjoined from denying coverage of Retrovir to persons eligible for Medicaid and infected with the AIDS virus." Weaver v. Reagen, 701 F.Supp. 717, 726 (W.D. Mo. 1988). In acknowledging the medical necessity for this type of treatment, the 8th Circuit invalidated Missouri's decision to restrict Medicaid reimbursements for Retrovir treatment to only those persons who met certain medical conditions.[7] In

[7]Weaver, 886 F.2d at 200. The Missouri Medicaid program's clinical prerequisites were that a person have either a history of cytologically confirmed Pneumocystis carinii pneumonia (PCP) or an absolute CD4 (T4

doing so, the Eighth Circuit effectively expanded the group of people that would be legally entitled to Medicaid payments for this type of AIDS-related treatment. A district court in Kansas reached a similar outcome two years earlier. See Mair v. Barton, 705 F.Supp. 520 (D.Kan. 1987).

Virtually all states have opted to fund AZT treatments for Medicaid recipients. National Gay Rights Advocates, Access to AIDS-Related Drugs Under Medicaid: A Fifty State Analysis, reprinted in AIDS Reference Guide: A Sourcebook for Planners and Decision Makers (Atlantic Info. Services) ¶ 326, at 3 (Aug. 1989). In view of this present voluntary commitment by the vast majority of state Medicaid agencies to prophylatic treatments, a sudden and significant increase in the number of AIDS-related

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helper/inducer) lymphocyte count of less than two hundred per cubic millimeter). Id. at 196.

Medicaid recipients clearly threatens the viability of these programs. Medicaid programs across the nation would face the unenviable choice of either restricting reimbursements for prophylatic treatments or incurring greater budget deficits to accomodate the needs of an expanded Medicaid-dependent population. By indirectly enlarging that population, the Fifth Circuit's decision will force Medicaid into this dilemma.

The undesired shift in health care financing portended by the Fifth Circuit's ruling also endangers the other component of the nation's health care "safety net": hospitals which provide uncompensated care. Two primary factors generate the need for uncompensated care, and the lower courts' decisions exacerbate both of them. The first consideration is the number of uninsured. Obviously, the greater the

population of patients whose care will not be reimbursed in full by private insurance, the greater the burden on hospitals to provide medical care free of charge. An unfortunate reality of the HIV/AIDS crisis is that a disproportionate number of persons with AIDS are uninsured. In 1989, 12.9% of the nation's population was not covered by either private or public health insurance. 1991 HIAA Source Book, supra, at 25. In marked contrast, 29% of the AIDS population is without insurance. National AIDS Commission Report, supra, at 70. Thus, the AIDS epidemic already requires an above-average amount of uncompensated care.

The other factor relates to Medicaid. Given Medicaid's policy of low reimbursement rates and the nation's imbalanced dependence on Medicaid for AIDS-related health care expenses,

hospitals serving AIDS patients who are Medicaid recipients will, in general, find themselves having to assume a significant amount of unpaid costs. As noted by a major hospital organization, "Without adequate public coverage, AIDS care will be 'paid' for in the form of uncompensated care for uninsured AIDS patients . . . ." AHA Report, supra, at 46. In this respect, the fate of uncompensated care is intertwined with the fate of Medicaid.

Since these two factors have figured so prominently in the HIV/AIDS crisis, it is not surprising that AIDS-related uncompensated care is sizable. Nevertheless, its extent is shocking, especially in relation to other uncompensated care. Comprehensive national survey data reveals that hospitals incurred a daily average of $136 in losses per AIDS patient. Dennis P.

Andrulis, Virginia Beers Weslowski & Larry S. Gage, The 1987 US Hospital AIDS Survey, 262 JAMA 784, 788 (1989) [hereinafter Hospital AIDS Survey]. By comparison, hospitals lost only $26 per non-AIDS medical/surgical patient, or less than 1/5 the loss stemming from the AIDS patient. To say that AIDS-related uncompensated care severely tests the financial well-being of the nation's hospital system is an obvious understatement. By allowing employers to engage in discriminatory practices with regard to health benefits, the Fifth Circuit's decision demands even greater levels of uncompensated care from an already heavily burdened hospital system.

The uncompensated care issue has an interesting twist to it. Apparently, a dichotomy exists in the sharing of this burden, and it occurs along the lines of

the public-private distinction. While both public and private hospitals do sustain losses on AIDS patients, the public hospital's unpaid bill is more than twice that of the private hospital.[8] The underlying description of this phenomenon suggest a troubling dimension to AIDS-related uncompensated care:

> Public hospitals admitted a significantly higher percentage of PWAs [persons with AIDS] whose payer source was Medicaid (52% of admissions to private institutions) and a higher proportion of self-pay/other [generally the uninsured or the indigent] (31% vs 13% for private hospitals). Private hospitals admitted a larger proportion of patients who were privately insured (48% vs 13% for public hospitals.

Id. at 789.

In general, public hospitals shoulder more of the burden of caring for those

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[8]The private hospital's loss per patient per day stands at $92, in contrast to the public hospital's figure of $218. Hospital AIDS Survey, supra, at 788. This disparity is not reserved for AIDS-related care: private hospitals, on average, gain $12 per day per non-AIDS patient while public hospitals face a loss of $131. Id.

persons with AIDS who are least able to pay for their care. Yet, "public hospitals treated, on average, more than twice as many AIDS patients as private hospitals in 1987." Id. at 786. Accordingly, "public hospitals have been experiencing significant economic losses when they provide care to AIDS patients." National AIDS Commission Report, supra, at 75. Thus, the more public hospitals undertake to provide care to those deprived of private insurance, the more they place themselves in a position of being financially unable to respond to this need for uncompensated care. As this need for uncompensated care increases in response to the kind of employer behavior sanctioned by the Fifth Circuit, the financial health of those very hospitals which are disproportionately providing care to persons with AIDS in

dire need of free or near-free care will be adversely impacted even more.

The potential size of the damage is staggering. If presently commercially insured employers do convert to self-insurance to take advantage of penalty-free alteration of employee health benefits, Medicaid and uncompensated care will face an onslaught of AIDS-related health care costs. In 1989 alone, AIDS-related employee health care claims paid by the insurance industry amounted to $455 million. Christine Woolsey, AIDS Claims Hit $1 Billion, Bus. Ins., Oct. 29, 1990, at 1. This represents "an alarming 83% increase" from such payments in 1988. Id. Moreover, insurance industry observers acknowledge that these figures probably understate the actual amount of payments made by insurance companies on employee

AIDS-related health insurance claims. Id. at 38.

These developments clearly threaten the integrity of the health care "safety net". The strain on public hospitals "erodes their ability to provide specialized services and threatens their traditional mission as the provider of last resort of the indigent." AIDS Update: An Executive Report--Public Hospitals Bear Brunt of AIDS Treatment Load, Hospitals, May 5, 1990, at 26. Both public and private hospitals have financed the burden of uncompensated care in the form of higher health care costs to the public as a whole. However, "as competition decreases the ability of hospitals to shift these costs, hospitals may find themselves struggling to meet the needs of AIDS patients." AHA Report, supra, at 46. In essence, this struggle

depicts the overall problem: as the responsbility of caring for HIV-infected persons becomes increasingly a matter that Medicaid and uncompensated care address by default, the ability of the entire "safety net" to respond to other similar public health crises is seriously compromised.[9]

C. The use of McGann-like health benefit caps unconscionably denies many HIV-infected individuals access to the most effective life-prolonging and medically necessary treatments available.

The health benefit caps condoned by the Fifth Circuit have a direct bearing on the quality of health care that formerly-insured employees must receive if they become or are infected with HIV. Sadly, Medicaid's established reputation as a

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[9]"If financial responsibility [is] shifted to the public sector, limited resources would be diverted to individuals who would otherwise be able to finance their own care. These resources then would not be available for those with significant need or for other vital programs." AHA Report, supra, at 39.

below-market-price reimburser limits a Medicaid recipient's accessiblity to the medically necessary level of care.

> [P]hysicians have financial disincentives to provide care to individuals on Medicaid. Physician reimbursement rates under Medicaid are much lower than those from other third-party payers . . . . In this climate, not only may patients be forced to wait for care until serious symptoms develop, but they then are likely to be driven for lack of alternatives to seek care in the more expensive hospital emergency room or inpatient setting.

National AIDS Commission Report, supra, at 75.

Moreover, though it is heartening that hospitals extend uncompensated care to the uninsured, that care is generally inferior. In several key categories measuring patient well-being, privately insured hospital patients fare better than their uninsured counterparts. For instance, where a high-cost/high-discretion hospital procedure is involved, "the uninsured's length of stay is

significantly shorter than the length of stay for the privately insured . . . ." Jack Hadley, Earl P. Steinberg & Judith Feder, Comparison of Uninsured and Privately Insured Hospital Patients, 265 JAMA 374, 377 (1991). Related to this is the fact that there are "highly significant and quantitatively large differences between uninsured and privately insured patients in the probability of undergoing these procedures." Id. The final and perhaps most sobering observation is that "the uninsured have a higher relative risk of in-hospital death than the privately insured." Id. at 379.

One of the most hopeful discoveries in the battle against AIDS and HIV-infection is the use of AZT. As mentioned earlier, these types of drugs delay the onset of crippling opportunistic diseases

like PCP. Since the AIDS virus devastates the body's immune system, opportunistic diseases normally kept at bay are free to wreak havoc within that body. In essence, the fatality of AIDS stems from these diseases. Yet, although the drug AZT was originally targetted for HIV-infected persons who had developed PCP, subsequent medical studies have established that AZT is equally efficacious when administered in a prophylatic mode. Consequently, "[the Centers for Disease Control] estimates that approximately 60 percent of HIV-infected individuals would benefit from immediate treatment with [AZT]." National AIDS Commission Report, supra, at 75.

One setback with both the prophylatic and the intial use of AZT has been the toxicity associated with originally prescribed dosage levels. Volberding,

supra, at S7, S9. Definitive clinical studies now recommend that lower dosages can be applied without fear of reducing the effectiveness of AZT at any stage of HIV infection: asymptomatic, early, or advanced HIV disease. Id. at S9-S11. While AZT--as well as other drugs under investigation--is not a "miracle drug", its value to anti-HIV-disease treatment is substantial. Thus, ready access to AZT is an urgent priority for improving the lives and extending the life spans of HIV-infected persons.

AIDS-specific employee health benefit caps represent a direct threat to this critical access. Caps also severely harm an employee who suffers from an opportunistic disease. Amici do not attack the concept of cost-containment in general. However, cost containment cannot be disciminatory under ERISA. Therefore,

amici urge the Cour to recognize this "cost-cutting" tactic undertaken by H & H Music Company and supported by the Fifth Circuit for what it really is--an illegal death-promoting denial of promised employee health benefits.

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

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March 3, 1992

MAR 3 1992

No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

— v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MOTION AND BRIEF OF BAY AREA LAWYERS FOR INDIVIDUAL FREEDOM AND GAY AND LESBIAN ADVOCATES AND DEFENDERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER.

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Respondents.

MOTION FOR LEAVE TO FILE BRIEF AS AMICI CURIAE

The Bay Area Lawyers for Individual Freedom ("BALIF") and the Gay and Lesbian Advocates and Defenders ("GLAD"), by their attorney, move this Court to grant them leave to file a brief in support of the Petition for Grant of Writ of Certiorari, and in support of this motion, show as follows:

1. The Defendants H & H Music Company, Brook Mays Music Company, and General American Life Insurance Company have refused consent to the submission of this *amici curiae* brief.

2. Applicants' interest in the issues in, and the outcome of, this petition arises from their endeavors to ensure fair and equal treatment for People With AIDS in the areas of employment and health care, as more fully articulated in the Statement of Interest of *Amici Curiae*.

3. Applicants believe that a brief amici curiae, submitted by applicants, would be desirable in that the issues involved in this case concern not only the parties and applicants, but are also of considerable public interest and import, and it is therefore highly important that Petitioner's position be developed and presented fully.

Respectfully submitted,

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici Bay Area Lawyers for Individual Freedom and Gay & Lesbian Advocates and Defenders share a common professional opinion--that insurance benefit caps are contrary to the law, damaging to the nation's health care system, seriously detrimental to the people with HIV infection who are subject to them, inherently discriminatory, and based on misconceptions regarding the relative cost of caring for people with HIV disease.

Bay Area Lawyers for Individual Freedom ("BALIF") is an organization of more than five hundred lawyers, legal workers and law students in the San Francisco Bay Area, founded in 1980 to protect and further t -egal and professional interests of lesbians and gay men and, more broadly, to seek justice for sexual

minorities under the law. BALIF has participated in the preparation and filing of a number of amicus curiae briefs in important state and federal gay and lesbian rights cases, including Bowers v. Hardwick, 478 U.S. 186 (1986); Watkins v. U.S. Army, 875 F.2d 699 (9th Cir. 1989), cert. denied, 111 S.Ct. 384 (1990); Westpac Audiotext, Inc. v. Wilks, 756 F. Supp. 1267 (N.D. Cal. 1991); and Johnetta J. v. Municipal Court, 218 Cal App. 3d 1255 (1990). In 1983, BALIF founded the AIDS Legal Referral Panel, the nation's largest provider of legal services to people with AIDS.

Gay and Lesbian Advocates and Defenders ("GLAD") is a public interest legal organization which does litigation and educational work

on lesbian and gay civil rights issues and, through its AIDS Law Project ("ALP") does similar work against HIV-related discrimination. A large part of the ALP caseload involves access to medical treatment and insurance-related matters, and ALP clients are adversely affected by caps on medical benefits for AIDS-related care.

Amici submit this brief so that this Court will have available for its deliberations an accurate statement of the position of AIDS advocacy organizations regarding the important issues presented by this appeal.

STATEMENT OF THE CASE

Amici rely on the Statement of the Case set out in Brief for Appellants.

SUMMARY OF THE ARGUMENT

Employers have discretion in the composition of their benefit packages under ERISA, even in whether to offer a benefit plan at all. Employers are, however, subject to the anti-discrimination policy embodied in §510, 29 U.S.C. §1140. In affirming the summary judgment order against Plaintiff-Appellant John McGann, the Fifth Circuit essentially eliminated a cause of action under §510 when the alleged discrimination involved the termination or amendment of welfare benefit plans. Such an interpretation of §510 renders the provision meaningless, as employers may accomplish through amendment or termination of a plan what they could not accomplish through termination of the employee--avoiding payment of medical expenses. Under the Fifth Circuit's interpretation of ERISA, employers may

offer employees illusory benefit packages by altering benefit plans whenever they do not wish to pay certain claims.

The Fifth Circuit has narrowed §510 to such an extent that it placed an unreasonably difficult burden on employees filing §510 claims. According to the Fifth Circuit, employers may effectively guarantee victory on a summary judgment motion in a §510 claim by putting forth a cost-saving defense, no matter how disingenuous. When an employer has drastically capped one illness, while retaining practically unlimited coverage for other illnesses of comparable cost, the employer is either misrepresenting the depth of its pocket or the veracity of its entire benefit plan. ERISA does not allow employers to deceive their employees in either manner, and therefore the Fifth Circuit erred in holding that summary

judgment for the Respondents was necessary as a matter of law.

An employee with promised health insurance coverage of $1 million would not anticipate the need to seek out further insurance. The employee relies upon the promised health insurance benefit and could not insure against the employer modifying benefits. The provisions of §510 are designed to protect against withdrawal of provided benefits.

Small employers are increasingly adopting self-insured plans, since decisions such as the Fifth Circuit's assure them that cutting and capping benefits are valid procedures. The protections of §510 must not be construed so narrowly as to encourage employers to take refuge from appropriate state insurance law under the umbrella of ERISA.

ARGUMENT

THE FIFTH CIRCUIT ADOPTED AN UNDULY NARROW INTERPRETATION OF ERISA §510, WHICH MUST BE READ TO PROHIBIT THE AMENDMENT OR TERMINATION OF WELFARE BENEFIT PLANS IN A MANNER WHICH WILL DEPRIVE AN INDIVIDUAL OR GROUP OF INDIVIDUALS FROM RECEIVING EXPECTED BENEFITS.

A. Section 510 of ERISA was implemented as a protection of employee rights and must be construed broadly to carry out this purpose. The Fifth Circuit adopted an unduly narrow interpretation of §510 which circumvents Congressional intent.

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001 et seq. "is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1982). ERISA grew out of Congressional concern over abuses in the administration of welfare and pension plans, which directly affect "the continued well-being and

security of millions of employees and their dependents," but which, at the time, were lacking in "adequate safeguards concerning their operation." 29 U.S.C. §1001(a). ERISA was intended to prevent the deprivation of anticipated benefits, and provided "minimum standards . . . assuring the equitable character of such plans and their financial soundness." Id. (emphasis added). ERISA is remedial legislation, and as such, must be "liberally construed in favor of employee benefit fund participants." Kross v. Western Elec. Co., 701 F.2d 1238, 1242 (7th Cir. 1983). See also Vogel v. Independence Fed. Sav. Bank, 728 F. Supp. 1210, 1221 (D. Md. 1990).

ERISA was created primarily as a safeguard for pension plans, ensuring protections through vesting and funding requirements, fiduciary rules, reporting

and disclosure requirements, a termination insurance system, and enforcement and remedial measures. John H. Langbein & Bruce A. Wolk, Pension and Employee Benefit Plans 413 (1990). Welfare benefit plans, including health benefits, are covered by three parts of ERISA--the reporting and disclosure requirements, the fiduciary rules, and the enforcement and remedial measures. Id. The term "welfare benefit plan" encompasses

> any plan, fund or program . . established or maintained by an employer . . . to the extent that such plan . . . was established or is maintained for the purpose of providing . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death.

29 U.S.C. §1002(1). Both welfare benefit plans and pension plans are included in the term "employee benefit plan." 29 U.S.C. §1002(3). Though welfare benefit plans do not "vest" under ERISA, all

employee benefit plans, both welfare benefit plans and pension plans, are equally protected under the anti-discrimination provision of ERISA, §510, which reads as follows:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

29 U.S.C. §1140. The import of this provision is clear; employers must not discriminate against an individual who attempts to claim the benefits that were promised to him or her under the employee benefit plan. The Fifth Circuit read this provision in an extremely narrow manner which distorts and diminishes the protections of §510.

When the Fifth Circuit affirmed summary judgment against John McGann it operated under several presumptions. First, it presumed that since the right to medical benefits does not vest under FRISA and the employer reserved the right to alter the plan, employees have no expectation interest in the benefits that are promised to them under employee welfare benefit plans, and that therefore these benefits can be removed at any time without the employer violating §510. McGann v. H & H Music Co., 946 F.2d 401, 405 (5th Cir. 1991). Secondly, the Court presumed that since any current or future employee who contracts AIDS will also be held to the five thousand dollar limit on medical expenses, H & H Music Company and General American Life Insurance were not taking action against McGann as an individual. McGann, 946 F.2d at 404. The

Court found reinforcement for the latter conclusion in the fact that McGann did not allege any specific intent on the part of H & H Music Company other than the intent to avoid paying his medical expenses. Id. These presumptions led to a result that is inequitable and blatantly contrary to the purpose of ERISA.

The Fifth Circuit viewed the lack of vesting as determinative. The court first found that McGann presented no evidence that "[t]he continued availability of the $1,000,000 limit was not a right to which McGann may have become entitled for the purposes of §510," since such a right must relate to "an existing, enforceable obligation." McGann, 946 F.2d at 405. The Court explained that "Congress viewed [section 510] as a crucial part of ERISA because, without it, employers would be able to circumvent the provision of

promised benefits." McGann, 946 F.2d at 405, citing Ingersoll Rand Co. v. McClendon, 498 U.S. ---, 111 S. Ct. 478 (1990) (emphasis in original). The Fifth Circuit then erroneously equated the concept of vesting to that of a promised benefit, holding that "McGann's allegations show no promised benefit, for there is nothing to indicate that defendants ever promised that the $1,000,000 coverage limit was permanent." Id.

Congress, unlike the Fifth Circuit, did not equate vesting with promised benefits. Kross, 701 F.2d at 1238. Welfare benefit plans are exempted from the vesting requirements of ERISA because of the nature of such plans as opposed to pension plans. Pension plan "[b]enefits accrue across decades of employment and are distributed across further decades of

retirement. Welfare benefit plans, by contrast, provide services or other benefits on a 'current account' or 'pay as you go' basis . . . [T]hese entitlements do not ordinarily cumulate over time." Langbein & Wolk, supra, at 413. The distinction is based solely on whether the benefit accumulates. Pensions grow over years of employment, as money is continually invested into the pension fund. In contrast, health coverage does not accumulate as the years go by, but is either used or declined at any given time. Id. This does not mean, however, that health benefits are not "promised" or "expected" benefits.

Other Circuits specifically reject the idea that employees are not entitled to anticipated benefits that have not vested. "Congress would not have adopted such broad and encompassing language" had

it intended such a narrow interpretation. Kross, 701 F.2d at 1242. Moreover, this Court has recognized that Congress, in enacting ERISA as a remedial statute for the benefit of employees, intended that "'appropriate equitable relief'" would grow around ERISA. Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). Such equity demands that the statute not be narrowed by illogical constructions.

At the time McGann notified his employer that he was ill and submitted his first reimbursement claims, H & H Music Company's health plan offered $1,000,000 worth of medical benefits for all illnesses, through a combination of self-insurance and its group medical plan issued by General American Life Insurance. McGann, 946 F.2d at 403. To the extent that the policy indicated a certain amount

of coverage, that amount was promised. An employee who believes he or she is covered to that extent would not foresee the near elimination of coverage for a specific disease; such an employee would be unlikely to purchase a supplemental health insurance policy. There is no secondary insurance market to which an employee could turn to purchase coverage in the event of limitation of his or her benefits by an employer. Thus, employees place great reliance on their work-related benefits, and employers must have a duty to treat their employees equitably in the administration of such benefits.

The Fifth Circuit also erred in concluding that since this change would effect "any other present or future plan beneficiary who might suffer from AIDS," McGann had failed to meet his burden of proving intent to violate §510. McGann,

546 F.2d at 404. Section 510 claims may be established either by an individual employee or "certain identified groups of employees." Aronson v. Servus Rubber, Div. of Chromalloy, 730 F.2d 12, 16 (1st Cir. 1984), cert. denied 469 U.S. 1017 (1984). See also Kross at 1239 (class action brought under §510). Nothing in the plain language of the provision indicates that the action must affect only one person.

Furthermore, the Fifth Circuit actually noted in its opinion that "the defendants' knowledge of McGann's illness was a motivating factor in their decision to reduce coverage for AIDS-related expenses." McGann, 946 F.2d at 404, n. 4. Given that John McGann was the only employee of H & H Music Company who was known to have AIDS, it is illogical to conclude that this action wasn't taken

specifically to deprive him of coverage. Moreover, even if the change in benefit plans was solely motivated by a desire to save costs, the manner in which H & H Music Company amended the plan signalled discriminatory intent. For this reason alone, the Respondents were not entitled to a summary judgment ruling in their favor.

The plaintiff did not propose a complete ban on the amendment or termination of benefit plans. ERISA does acknowledge that employers may amend or terminate their plans, but §510 proscribes the amendment or termination of plans when such action is taken against specific individuals, affecting the benefits they would have otherwise received. See Vogel, 728 F. Supp. at 1225. H & H Music Company reserved the right to amend the benefit plan "at any time." The Fifth Circuit

believed that this reservation clause removed any expectation that McGann would have in his benefits. While such reservation clauses might be permissible within limits, employers must not be allowed to abuse them. The ability to terminate or amend "at any time" must not extend beyond the ability to amend or terminate given to employers under ERISA. Employers are limited by §510, and must act free of discrimination.

The full import of the Fifth Circuit's decision is best illustrated through several hypothetical scenarios. The pertinent question in each of these scenarios is whether employers should be allowed to amend or terminate health benefit plans. In the first scenario, an employee has incurred medical expenses and is awaiting reimbursement or payment from an employer-provided benefit plan. A

second scenario involves an employee who has notified the employer of an illness, but who has not yet incurred any medical expenses. The final scenario involves an employer who is unaware of any illnesses and who does not anticipate paying out benefits in the immediate future.

The Fifth Circuit's holding may be read to give an employer free rein to amend or terminate plans during any of these scenarios. That interpretation ignores the limitations imposed on employer discretion by §510. Giving employers such broad discretion, while reading §510's prohibitions so narrowly, renders §510 toothless.

Although ERISA gives employers the right to form their benefit plans freely, the statute does not give employers the right to offer illusory benefits. This is exactly the result to which the Fifth

Circuit's decision leads. The import of the Court's decision is that employers will be free to offer benefits to employees that will never be paid out. It is well-established that terminating an employee for the purpose of interfering with the attainment of welfare benefits is a violation of ERISA §510. See Folz v. Marriott Corp., 594 F. Supp. 1007 (W.D. Mo. 1984) (employer violated §510 when it terminated employee after he contracted multiple sclerosis). Section 510 coverage is not limited, however, to dismissal of employees. Congress included the broad term "discriminate" in its list of prohibited activities. "Discriminate" should encompass any activity that would undermine the purpose of ERISA. See, e.g., Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 489 (2d Cir. 1988).

A more appropriate interpretation of §510 recognizes that an employer cannot amend an employee's benefits during either of the first two hypotheticals: that, as a rule, amending benefits is per se discrimination when a certain employee or group of employees will lose benefits that are currently necessary to ensure continued or imminent medical care. Alternatively, the statute might be interpreted as allowing employers to amend medical benefit plans during any of these three scenarios, as long as it is done in a reasonable manner. Cuts across the board, with illnesses of comparable cost capped at the same amount, and without any indication that the change was inspired by employees' illnesses would not violate §510. Retaining full coverage for most illnesses while drastically capping one disease signals discrimination. In this

case, the signal was as clear as a lighthouse beacon.

B. The Fifth Circuit Has Imposed an Insurmountable Burden On Plaintiffs in §510 Cases; The Allegation of Cost-Saving Motivation Should Be Sufficient as Prima Facie Proof of Discriminatory Intent.

The Fifth Circuit found McGann's allegation that his employer was trying to avoid paying for the costs of AIDS as insufficient evidence of discriminatory intent under §510, so that McGann could not survive the Respondents' motion for summary judgment. The Court was clearly in error on this point, since McGann had met the elements of a prima facie case of discrimination under §510, and in light of the evidence that the Respondents' cost-cutting excuse was pretextual.

In determining whether a plaintiff has established a §510 claim, courts apply

the standards for claims brought under Title VII of the Civil Rights Act of 1964, 42 U.S.C. §2000e et seq. and the Age Discrimination in Employment Act, 29 U.S.C. §623 et seq. See Dister v. Continental Group, Inc., 859 F.2d 1108 (2d Cir. 1988). A prima facie case of a §510 violation is made when the plaintiff demonstrates (1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled. Gavalik v. Continental Can Co., 812 F.2d 834, 852 (3d Cir. 1987). A plaintiff in a §510 claim meets his or her initial burden by establishing a prima facie case by a preponderance of the evidence; at that point, an employer has the burden of articulating a legitimate, nondiscriminatory reason for its actions, or of suggesting "that it would have

reached the same decision or engaged in the same conduct in any [event]." Gavalik, 812 F.2d at 853, 863; See also Dister, 859 F.2d at 1111, 1112. Such a showing rebuts the presumption of discrimination created by the plaintiff's prima facie case. Dister, 859 F.2d at 1112. A plaintiff then has the chance to "demonstrate that the employer's articulated reason is pretextual, 'either directly by persuading the court that a discriminatory reason more likely motivated the employer or indirectly by showing that the employer's proffered explanation is unworthy of credence.'" Gavalik, 812 F.2d. at 853, quoting Texas Dep't of Community Affairs v. Burdine, 450 U.S. 248, 256. (1981).

The United States District Court for the Southern District of Texas adopted the three prong test of Gavalik, but

misapplied the test in its grant of summary judgment. McGann, 742 F. Supp. 392, 394 (S.D. Tex. 1990). The court felt that "Plaintiff cannot prove that Defendants' conduct was prohibited. The Defendants had the right to change or terminate the medical plan under ERISA. In addition, the action was not taken to interfere with the rights of McCann [sic] but to ensure the future existence of the plan." Id.

The primary error on the part of the District Court was the determination that this conduct is never prohibited. By reading the first prong of the Gavalik test in this manner, the District Court would make it impossible to bring a claim under §510. It is circular to say that in order for conduct to be prohibited by §510, it must be conduct that is already prohibited. Courts should instead

interpret "prohibited conduct" to mean that employers may not "discharge, fine, suspend, expel, discipline or discriminate" against an employee. 29 U.S.C. §1140. All of the listed acts are permissible as long as they are not taken in violation of §510.

The Fifth Circuit compounded the error in affirming the District Court decision. The Fifth Circuit found that McGann did not establish a prima facie case of discrimination because, in their view, he had not articulated a question of fact to be decided at trial. McGann, 946 F.2d at 408. The Court essentially agreed with the District Court that amending or terminating medical benefits was not discriminatory action within the meaning of §510. Id. at 407-08. Yet the Cour indicated that if McGann had alleged that H & H Music Company and General American

Life Insurance were specifically trying to keep him from receiving benefits, he might have established a prima facie case sufficient to withstand Respondents' summary judgment motion. Id. at 404. Nonetheless, the Fifth Circuit refused to find McGann's version of the facts adequate for this purpose, and seemingly found irrelevant the fact that McGann's employer admitted its motivation to avoid payment of McGann's medical expenses.

Both the District Court and the Fifth Circuit erred in finding that this cost-saving rationale precluded a prima facie case of discrimination under §510. Under each of these decisions, no plaintiff will ever be able to establish a prima facie case of §510 violation when an employer had amended or terminated their welfare benefit plans and has plead a cost-saving rationale. As far as requiring an

employee to articulate specific discriminatory intent directed at him- or herself, rarely, if ever, will the employee be able to show that no other individuals will be affected in the future when the employer conduct is manifested through benefit caps. Secondly, the employer will necessarily be able to articulate a cost-saving rationale for its action in all benefit cap cases. Such a rationale must not be so heavily weighed as to completely preclude a full hearing on the issue of whether an employee was targeted as an individual.

The action taken by the employer in the case at bar was particularly egregious, and therefore should be looked upon with even greater suspicion, yet neither lower court gave McGann the opportunity to prove that the cost-saving argument was an illegitimate, pretextual

reason. The lower courts failed to substantially address the fact that the five thousand dollar cap on AIDS and AIDS-related illnesses was drastically low compared to the previous limit of $1,000,000, and compared to the coverage retained for other illnesses. When employers drastically reduce the coverage of one illness while retaining the original coverage of illnesses that are comparable in expense, the fallaciousness of their cost-cutting arguments becomes obvious.

Indeed, AIDS is not unusually expensive as compared to other serious illnesses. The average lifetime costs for a person with AIDS has recently been estimated at between $75,000[1] and $85,333[2].

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[1]Fred J. Hellinger, Updated Forecasts of the Costs of Medical Care for Persons with AIDS, 1989-1993, 105 Pub. Health Rep. 1 (1990) [hereinafter Hellinger 1989-1993 Forecasts].

[2]Fred J. Hellinger, Forecasting the Medical Care Costs of the HIV Epidemic, 1991-1994, 28

While increasing amounts of money are being spent on AIDS, this is due to an increase in people diagnosed with AIDS, not greater individual expense. See Christine Woolsey, Employers Ill-Prepared for AIDS, Bus. Ins., Oct. 7, 1991, at 1, 75. Furthermore, the amount of health insurance spent on AIDS as a percentage of the total health insurance claims in the nation remains stable. See Steven Brostoff, AIDS-Related Life Insurance Claims Jumped in 1990, National Underwriter, Oct. 7, 1991, at 3.

The costs of many common ailments and procedures equal or exceed those of AIDS and AIDS-related illness. The costs of liver transplants have been estimated from $145,000[3] to $235,000[4]. A kidney

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Inquiry 213 (1991) [hereinafter Hellinger 1991-1994 Forecasts]..

[3]Sarah Henry, AIDS and Insurance Costs, Washington Post, Nov. 12, 1991, at H16.

transplant is estimated to cost $51,000[5], while end-stage kidney disease might cost as must as $158,000[6]. A heart transplant can c up to $148,000[7] and the costs of acute myocardial infarction have been estimated from $51,211[8] to $66,800[9]. The average costs for a cancer patient in the last six months of life alone has been calculated as high as $29,249[10]. Yet none of these illnesses or procedures were capped under H & H Music Company's self-insured plan.

Christine Woolsey, How to Live with the Costs as Workers Live with AIDS, Bus. Ins. Oct. 7, 1991, at 87 [hereinafter Woolsey Costs].

[5]Id.

[6]Daniel M. Fox & Emily H. Thomas, AIDS Cost Analysis and Social Policy, 15 Law, Med. & Health Care 186 (1987-88).

[7]See Woolsey Costs, supra, at 87.

[8]Ellison H. Wittels, Joel W. Hay & Antonio M. Gotto, Medical Costs of Coronary Artery Disease in the United States, 65 Am. J. Cardiology 432 (1990).

[9]See Fox & Thomas, supra, at 186.

[10]Cancer Care and Cost 119 (Richard M. Scheffler & Neil C. Andrews eds. 1989).

Furthermore, H & H Music Company's action may be pretextual in a second sense. If H & H Music Company did not have enough resources to cover McGann's expenses, then surely it did not have enough to cover future catastrophic claims. If this is the case, then H & H Music Company would systematically deny its employees medical coverage when their bills became too high for H & H Music Company to cover. As each major catastrophic claim arose, either the individual with the illness would have to be singled out for benefit-reduction, or H & H Music Company would be forced to bankrupt itself. Employers must not be encouraged to offer their employees only illusory benefits.

In the face of such a discrepancy between coverage for other illnesses and coverage for AIDS, John McGann must be

found to have articulated a prima facie case of §510 violation. "The specific intent to violate ERISA §510 may, of course, be 'satisfied by the introduction of circumstantial evidence'. . ." Vogel, 728 F. Supp. at 1226 (holding that plaintiff did establish a prima facie case sufficient to withstand summary judgment), quoting Gavalik at 852. His allegation that H & H Music Company amended the benefit plan by capping AIDS benefits satisfied the first prong of the Gavalik test, because it was employer conduct that could be taken for a discriminatory purpose. McGann met the second prong of the Gavalik test when he alleged that H & H Music Company's action was taken to interfere with the attainment of his benefits, and he met the third prong of the test by alleging that he lost benefits to which he was entitled and to which he

may have become entitled. In sum, McGann had fully articulated a prima facie case of §510 violation, creating a presumption that the Respondents had discriminated against him within the meaning of ERISA. If this presumption went unrebutted by the Respondents, the District Court would have been obligated to enter judgment for McGann. See Gavalik at 852. Certainly, then, the District Court should not have given summary judgment to the Respondents.

Even if the lower courts felt that the cost-saving rationale rebutted the presumption of §510 violation, summary judgment should not have been entered for the Respondents. McGann retained the opportunity to show that H & H Music Company's rationale was mere pretext for discrimination, or even that the proffered rationale was an illegitimate basis on which to cap his benefits. An employer

who retains $1,000,000 coverage for the vast majority of illnesses cannot legitimately argue that it had capped one illness at $5,000 solely to save costs. Something spurred the employer to choose that certain illness. In this case, the catalyst was McGann's diagnosis of AIDS and his incurred expenses. The Respondents took action against McGann "for exercising [a] right to which he is entitled . . . [and] for the purpose of interfering with the attainment of any right to which [he] might become entitled." 29 U.S.C. §1140.

On a motion for summary judgment, the non-moving party is entitled to have all facts read in his or her favor. Conkwright v. Westinghouse Elec. Corp., 933 F.2d 231, 233 (4th Cir. 1991). Yet each lower court failed to weigh the above facts in McGann's favor, regarding them in

a light more favorable to the Respondents. The Fifth Circuit's affirmance of the District Court decision substantially strays from the traditional standards of summary judgment.

The Fifth Circuit correctly noted that "McGann must make a showing sufficient to establish the existence of a genuine issue of material fact with respect to each material element on which he would carry the burden of proof at trial." McGann, 946 F.2d at 404. It has been shown that McGann met his burden of establishing a prima facie case. McGann also retained the ultimate burden of persuasion on the discrimination issue. Gavalik, 812 F.2d at 852. Yet he merely needed to prove the existence of an issue of fact on this point; the fact that he was effectively singled out among all of H & H Music Company employees was enough to

prove the existence of a material fact. Nonetheless, each lower court denied McGann the opportunity to prove this by inexplicably holding that, as a matter of law, McGann could not prevail at trial.

C. Small Employers Are Increasingly Turning To Self-Insured Plans As A Means Of Escaping State Mandates and Prohibitions on Insurance Caps; Public Policy Requires That This Practice Be Discouraged.

ERISA §514 provides that ERISA "shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan." 29 U.S.C. §1144(a). ERISA preemption is quite broad, covering all pension plans and most fringe benefits. Among the few exemptions from the preemption provision are "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. §1144(b)(2)(A). Employee benefit plans are specifically excluded from the definition of insurer

under ERISA, however, and so are not subject to state insurance laws. 29 U.S.C. §1144(b)(2)(B).

While Texas state law is not controlling in this case, it illustrates the types of law that employers avoid when they adopt self-insured plans. Texas state law prohibits discriminatory treatment on the part of insurers, particularly:

> [m]aking or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder.

Tex. Ins. Code Ann. art. 21.21(4)(7)(b) (emphasis added). Texas law also forbids insurers from discriminating on the basis of handicap in the following provision:

> An insurer who delivers or issues for delivery or renews any insurance in this state may not refuse to insure, refuse to continue to insure, limit the amount, extent, or kind of

> coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonable anticipated experience.

Tex. Ins. Code Ann. art. 21.21-3 (emphasis added). When these insurance laws are read in conjunction with Texas' Human Rights Act, Tex. Labor Code article 5221K et seq., which prohibits discrimination in the "terms, conditions, or privileges of employment" because of handicap, and the Texas Deceptive Trade Practices--Consumer Protection Act, Tex. Bus. & Com. Code art. 17.41 et seq., which mandates fair treatment of purchasers of insurance, the conclusion looms that H & H Music Company and General American Life Insurance would be prohibited under state law from reducing McGann's benefits as they did.

Employers are increasingly turning to self-insured plans in order to escape

the more rigorous requirements of state regulation. E. Richard Brown, Access to Health Insurance, 46 Med. Care Rev. 349, 368 (1989). Albert B. Crenshaw, Employer Try to Cut AILS Costs: Firms say Self-Insurance Spares Them From Paying Certain Benefits, Washington Post, January 6, 1991, at H11. Jesus Sanchez, Ill Feelings Over Self-Insurance, L. A. Times, June 9, 1991, at D1, col. 2. One recent study revealed that "more than half the companies that converted to self-insurance say they did so to avoid state mandates for certain types of coverage." Henry, supra, at H16.

There has been a "substantial growth in self-insurance since the early 1980's," especially among large employers, who are more likely to self-insure. Brown, supra, at 367. The numbers of small employers who are self-insuring is growing rapidly,

however, and it has been estimated that 26.7 percent of small employers (with fewer than 99 employees) now self-insure. Id. Problems arise primarily with these smaller employers, "who lack the deep pockets to cover medical claims," and the effects of these problems are too often felt by the employees. Id.

As more employers perceive ERISA as a means of escaping state law, states will find a steady decrease in the amount of regulatory control they have over the traditional state arena of the provision and administration of health benefits. It is paradoxical that a federal statute intended to provide consistency in the administration of benefit and pension plans has become a refuge for those employers who wish to avoid providing tangible catastrophic coverage for their employees. Congress certainly didn't

intend this reaction when they included welfare benefit plans under ERISA, and hence removed a large share of employee benefit plans from state regulation.

> ERISA §514 effectively federalizes the entire law of welfare benefit plans, except in those respects in which the insurance savings clause or other exceptions preserve state law . . . . As a result, federal courts have displaced state courts in areas in which state law was often adequate . . . . There is little reason to think that Congress understood how ERISA preemption would magnify the consequences of the decision to federalize the fiduciary standards for nonpension plans.

Langbein & Wolk, supra, at 414. Section 510, as a regulatory provision checking employer discretion, must be read broadly so as not to disrupt the purpose of ERISA.

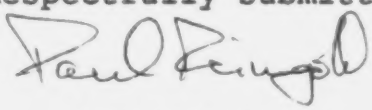
Furthermore, as far as it applies to health and disability benefits, ERISA should promote, rather than abrogate, the policies behind insurance law. "The purpose of insurance is to pool risks;

some will get sick or injured and others will not. If ERISA is to mean anything to employees and their families, it must prohibit employers from reducing insurance costs in ways that defeat this purpose." Joan Vogel, Containing Medical and Disability Costs by Cutting Unhealthy Employees: Does Section 510 of ERISA Provide a Remedy?, 62 Notre Dame L. Rev. 1024, 1030 (1987). Employers such as H & H Music Company should not be given the opportunity to eliminate all risks by eliminating real coverage for expensive diseases.

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

Respectfully submitted,



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IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, INDEPENDENT EXECUTOR
OF THE ESTATE OF
JOHN W. "JACK" McGANN,
Petitioner,

v.

H & H MUSIC COMPANY, BROOK
MAYS MUSIC COMPANY, and GENERAL
AMERICAN LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR RESPONDENT GENERAL AMERICAN LIFE INSURANCE COMPANY IN OPPOSITION

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QUESTIONS PRESENTED FOR REVIEW

1. Whether an employee has a right protected by § 510 of ERISA to continuous, uninterrupted group health insurance?
2. To prove discrimination under § 510, whether an employee need prove more than the employer's discriminatory intent to interfere with the employee's rights?
3. Whether the public would be better served by protecting employers' rights to control non-vested benefits or permitting the courts to determine which benefits must be offered?
4. Whether the termination and/or modification of group insurance benefits performed in accordance with the summary plan description can be discriminatory in violation of § 510 of ERISA?
5. Whether a nonemployer may be sued under § 510 of ERISA?
6. Whether a conspiracy to discriminate states a cause of action under ERISA?

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NO. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, INDEPENDENT EXECUTOR
OF THE ESTATE OF
JOHN W. "JACK" McGANN,
Petitioner,

v.

H & H MUSIC COMPANY, BROOK
MAYS MUSIC COMPANY, and GENERAL
AMERICAN LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR RESPONDENT IN OPPOSITION

Respondent submits this brief to demonstrate that the petition for writ of certiorari should be denied.

OPINIONS BELOW

On June 28, 1990, the United States District Court for the Southern District of Texas (Black, J.) entered summary judgment for the Respondents. The decision of the

district court is reported at 742 F. Supp. 392. On November 4, 1991, the United States Court of Appeals for the Fifth Circuit affirmed. The opinion of the Court of Appeals is published at 946 F.2d 401. The opinions have been printed in the appendix to the petition (Pet. App. 1A-43A). We have, therefore, not reprinted the opinions.

COUNTER-STATEMENT OF THE CASE

A. Nature of the Case:

Based upon the provisions of ERISA, 29 U.S.C. § 1001 *et seq.* and causes of action arising out of the laws of the state of Texas, Article 21.21 of the Texas Insurance Code and § 17.41 *et seq.* of the Texas Business & Commerce Code, Plaintiff/Petitioner, John McGann ("McGann") filed suit against Defendant/Respondent, General American Life Insurance Company ("General American") and Defendants/Respondents H & H Music Company ("H & H") and Brook Mays Music Company ("Brook Mays"). In addition to damages, McGann requested injunctive relief to have insurance benefits under a terminated medical insurance benefit plan restored. McGann claimed General American, H & H and Brook Mays Music Company conspired to discriminate against him and undertook deceptive practices in preventing him from exercising rights to which he alleged he was entitled under the provisions of an employee benefit plan. (Br. Opp. App. A).

General American filed a Motion for Summary Judgment (Br. Opp. App. B) and a supplement to that motion (Br. Opp. App. C) in which General American argued that McGann's allegations of discrimination under § 510 of ERISA were not actionable against General American because it was not McGann's employer. Alternatively, General Americain argued that McGann could not state

a cause of action under § 510 of ERISA. Finally, General American argued that the state court causes of action against it were preempted.[1]

The Trial Court, the Honorable Norman Black, granted General American's Motion for Summary Judgment finding "Defendants have the right to terminate the plan and complied with the requirements of ERISA." The Trial Court further stated that McGann's claims of discrimination were unfounded because McGann could not demonstrate the elements of discrimination: (1) prohibited employer conduct, (2) taken for the purpose of interfering with, (3) the attainment of any right to which the employee (McGann) may become entitled (Pet. App. 34A-43A). Summary Judgment was entered on June 28, 1990, for all Defendants/Respondents and the appeal ensued based solely upon an alleged violation of McGann's rights under ERISA. General American responded to the appeal arguing that the District Court was correct and that a nonemployer could not be sued under § 510 of ERISA.

On November 4, 1991, the Fifth Circuit affirmed the judgment of the Trial Court. Because it found that the respondents had not violated § 510 of ERISA, the Fifth Circuit determined it was not necessary to discuss the issue of whether a nonemployer could be held liable under § 510 of ERISA. *McGann v. H & H Music Co.*, 946 F.2d 401, 403 n.3 (5th Cir. 1991).

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1. Although General American's Motion for Summary Judgment included an argument that McGann's state court causes of action had been preempted under ERISA, McGann failed to raise this issue on appeal. Because McGann failed to preserve error regarding preemption, these causes of action have been abandoned and the trial court's judgment disposes of McGann's state court causes of action.

B. Statement of Facts

General American is an insurance company which provides group life and medical insurance plans. Prior to July 31, 1988, General American provided medical insurance to the employees of H & H Music Company pursuant to an agreement with Brook Mays (Br. Opp. App. D). H & H Music Company, according to the terms of ERISA, 29 U.S.C. § 1022(a)(1), provided its employees a Summary Plan Description ("SPD"). The SPD under the insurance plan in effect prior to July 31, 1988, stated that the plan's sponsor could terminate or amend the plan or terminate any benefit under the plan at any time (Br. Opp. App. D). The beneficiaries of the plan were put on notice that at any time their medical insurance could be changed or withdrawn.

John McGann, an H & H employee, was diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) in December 1987 (Br. Opp. App. A). His condition was made known to Respondents.

Subsequently, on July 28, 1988, Brook Mays announced that it was exercising its right to terminate the health insurance plan covering H & H employees (Br. Opp. App. E). Brook Mays stated that the plan would end on August 1, 1988, and a new group medical care plan would take effect. The plan that was terminated was a fully insured group medical plan provided by General American (Br. Opp. App. D). The employee benefit plan which started on August 1, 1988, was a self-insured plan (Br. Opp. App. F). To effectuate this self-insured plan, General American and Brook Mays entered into an administrative services agreement (Br. Opp. App. G). Pursuant to the terms of the agreement, General American received administrative services fees to administer and take

claims under the new plan (Br. Opp. App. G). Because Brook Mays' new plan was self-insured, no policy regarding medical benefits was issued to Brook Mays by General American (Br. Opp. App. B p. B11). The new SPD under the new self-insured plan provided all H & H employees medical benefits. However, there were several differences in medical benefits between the new and old plans including deductible and "stop loss" increases, employee contribution increases, exclusion of treatment for substance abuse, and the addition of a Preferred Provider Organization Network (Br. Opp. App. D & F). Among the differences, the self-insured plan provided benefits payable for AIDS related claims with the maximum life time covered expense of $5,000.

REASONS FOR DENYING THE WRIT

COUNTERPOINT I

THE FIFTH CIRCUIT'S APPLICATION OF § 510 IS CORRECT AND IN ACCORD WITH OTHER CIRCUITS.

The equation which must be met to demonstrate discrimination under § 510 of ERISA has three elements. Each element must exist to prove discrimination. To show discrimination under § 510, an employee must prove (1) prohibited employer conduct (2) taken for the purpose of interfering with (3) the attainment of any right to which the meployee may become entitled. *Gavalik v. Continental Can Co.*, 812 F.2d 834 (3d Cir. 1987), *cert. denied*, 484 U.S. 979 (1987). The Fifth Circuit devoted considerable attention to McGann's failure to prove the final element of this equation. Arguably, it was unnecessary to analyze the other two given McGann's

failure to demonstrate that he had a right to which he may become entitled.

McGann erroneously claims that the Fifth Circuit's opinion regarding his failure to adduce any evidence of the existence of any right to which he may become entitled conflicts with other circuits. To support this claim, McGann incorrectly interprets the Fifth Circuit's opinion to state that an employee only has a claim under § 510 when the employee complains of an interference with a right to a *permanent* benefit. McGann contends this is wrong because other circuits have permitted § 510 claims against employers who interfered with employees' rights to non-permanent benefits. The critical and blatantly omitted element which invalidates McGann's argument is that the employees who have been successful in asserting § 510 claims for the interference with non-permanent benefits have had their employment terminated to prevent them from exercising rights to the non-permanent benefits. McGann was not terminated. The insurance plan, which offered non-permanent/non-vested benefits, was terminated in accordance with the summary plan description.

The cases cited by McGann as being in conflict with the Fifth Circuit have a fact pattern which was not before the Fifth Circuit in the present case. In all of these cases the employee was terminated.[2] In the cases involving

2. Of note, some of the cases relied upon by McGann involve situations where the employee was terminated to prevent the employee from receiving permanent/vested benefits. *Ingersoll-Rand Co. v. McClendon*, __U.S.__, 111 S. Ct. 478, 112 L.Ed.2d 474 (1990); *Conkwright v. Westinghouse Elec. Co.*, 933 F.2d 231 (4th Cir. 1991); *Dister v. Continental Group, Inc.*, 859 F.2d 1108 (2d Cir. 1988). These cases have no similarity to the case at bar. McGann was not terminated and the dispute does not involve vested benefits. The legal arguments are also dissimilar to this case. For instance, the explicit holding of *Ingersoll-Rand* stands for the proposition that ERISA pre-empts a Texas common law cause of action for wrongful discharge taken for the purpose of avoiding pension fund payments.

nonvested benefits, the employee was fired to prevent the employee or his dependent from exercising a right under an *existing* benefit plan. *Fitzgerald v. Codex Corp.*, 882 F.2d 586 (1st Cir. 1989); *Kross v. Western Electric Co.*, 701 F.2d 1238 (7th Cir. 1983); *Zipf v. American Tel. & Tel. Co.*, 799 F.2d 889, 893 (3d Cir. 1986); *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984).

In *Fitzgerald, Kross, Zipf* and *Folz,* the Plaintiffs were all terminated to prevent them or their dependents from obtaining medical benefits under an existing welfare benefit plan. *Fitzgerald v. Codex Corp.*, 882 F.2d at 587; *Kross v. Western Electric Co.*, 701 F.2d at 1239; *Zipf v. American Tel. & Tel. Co.*, 889 F.2d at 890; *Folz v. Marriott Corp.*, 594 F.2d at 1010. None of these cases involved an employee suing to enforce or reinstate a terminated benefit plan or involved an employee claiming that termination of a benefit plan is discriminatory. Instead, the Plaintiffs were prevented from obtaining a right under an existing plan by their own termination. Section 510 of ERISA proscribes an employer's termination of an employee to avoid insurance claims. However, ERISA permits the termination of an employee welfare benefit plan to avoid claims. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

A second fallacious argument in McGann's first point of error states that "the Fifth Circuit's narrow construction of section 510 removes from employees any ability to rely on a benefit plan provided by an employer" (Pet. 11). This argument is invalid because employees have no right to rely on a nonpermanent benefit, particularly when the summary plan description explicitly states that the benefit may be changed or withdrawn. Also, ERISA does not provide a remedy for reliance upon insurance benefits.

Detrimental reliance on benefits is not actionable under ERISA. *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989). Contrary to McGann's contention, employees do not have the ability or right to rely on the permanence of a nonvested benefit plan. McGann therefore cannot create a right to $1 million worth of health insurance because he anticipated or relied upon its permanent existence.

The Fifth Circuit correctly held that employees do not have a permanent right to health insurance. The Fifth Circuit's opinion is consistent with the recognized distinction between an employees' rights with respect to vested and nonvested benefits.

When enacting ERISA, Congress distinguished between two types of benefits: normal retirement benefits (hereinafter "pension or vested benefits") and ancillary benefits (hereinafter "welfare or non-vested benefits"). *Phillips v. Amoco Oil Co.*, 614 F. Supp. 694 (N.D. Ala. 1985) *affirmed*, 799 F.2d 1464 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987). Under ERISA, new rights were bestowed upon employees covered by employers' pension plans. Most notably, ERISA provided that employees had vested, nonforfeitable rights to a certain percentage of their pension benefits based upon the number of years they were employed. 29 U.S.C. § 1053.

In contrast to vested pension benefits, welfare benefits are nonvested benefits, provided under medical and health plans, early retiremnet plans, or other benefits not considered part of the normal retirement benefit to which ERISA's nonforfeitable requirements apply. *Sutton v. Weirton Steel Division of National Steel Corp.*, 724 F.2d 406 (4th Cir. 1983), *cert. denied*, 467 U.S. 1205 (1984).

There was a reason for the exemption of welfare benefits from the protection of vesting. The vesting provisions would not deter employers from forming pension plans because those costs were easy to estimate; however, applying vesting provisions to the unpredictable expenses of welfare benefits, such as medical and health care insurance, would discourage employers from offering these benefits in the first place. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d at 492.

Unlike pension benefits, welfare benefits were not afforded any special protection under ERISA outside of the benefit contract between the employer and the employee. *Anderson v. Alpha Portland Industries Inc.*, 647 F. Supp. 1109, 1125 (E.D. Mo. 1986), *affirmed*, 836 F.2d 1512 (8th Cir. 1988). Employees cannot use the courts to create a protected interest in welfare benefits. such as health insurance. The plaintiffs/employees in *Musto v. American General Corp.* filed suit contending, in essence, that they had vested contractual rights in the medical benefits which prevented any change to their medical insurance contract. 861 F.2d 897, 900 (6th Cir. 1988), *cert. denied*, ____U.S.____ (1989). The Sixth Circuit failed to recognize this right, just as the Fifth Circuit has appropriately failed to recognize a vested or permanent right to medical benefits in McGann's case. The creation of vested or permanent rights to health insurance would require federal legislation. *Musto*, 861 F.2d at 911.

When the Fifth Circuit held that McGann had no permanent right or vested interest in a terminated health insurance plan, it was not in conflict with the other circuits. It followed them. Accordingly, certiorari should not be granted because there is no conflict with other circuits.

COUNTERPOINT II

THE FIFTH CIRCUIT HAS NOT CREATED A NEW STANDARD OF PROOF.

Contrary to McGann's claim, the Fifth Circuit did not create a new burden of proof for a plaintiff bringing a § 510 claim. In the decision the Fifth Circuit set forth the established burden of proof for a § 510 claim: (1) discriminatory intent (2) to interfere with the employee's rights.[3] After setting out the burden of proof, the Fifth Circuit described how McGann had failed to meet this burden by not putting forward any evidence that H & H and Brook Mays' intent to save money was discriminatory toward him. For instance, the Fifth Circuit stated that McGann had failed to show he was the only person affected by the changes in the insurance coverage and that cost-savings in this situation evidenced ill-intent toward *him. McGann,* 946 F.2d at 404-405. Without admitting that cost-savings by the employer is equivalent to true discriminatory intent, even if it were, it cannot create liability under § 510, absent proof that the intent was directed toward McGann, in particular, to interfere with a right to which he may become entitled. The courts

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3. "At trial McGann would bear the burden of proving the existence of defendants' specific discriminatory intent as an essential element of either of his claims. *Kimbro v. Atlantic Richfield Co.*, 889 F.2d 869, 881 (9th Cir. 1989) (employee must prove employer's specific intent to retaliate for employee's exercise of rights under plan) *cert. denied*, __U.S.__, 111 S. Ct. 53, 112 L.Ed.2d 28 (1990); *Clark v. Resistoflex Co.*, 854 F.2d 762, 770 (5th Cir. 1988) (employee must prove specific intent to interfere with employee's pension rights); *Dister v. Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988) (section 510 claimant must prove specific intent to engage in activity prohibited by section 510); *Gavalik v. Continental Can Co.*, 812 F.2d 834, 851 (3d Cir. 1987) (claimant must prove specific intent to violate ERISA), *cert. denied*, 484 U.S. 979, 108 S. Ct. 495, 98 L.Ed.2d 492 (1987)." *McGann*, 946 F.2d at 404.

recognize that modifications in group benefits will interfere with everyone's attainment of benefits, and are indeed expressly intended to interfere with the attainment of benefits. *Aaronson v. Servus Rubber Div. of Chromalloy*, 730 F.2d 12 (1st Cir.), *cert. denied*, 469 U.S. 1017 (1984). Here, McGann failed to show that the termination of benefits to save money proved to be discriminatory as to him and interfered with his rights.

The Fifth Circuit did not create a new burden of proof for plaintiffs in § 510 cases. Because its opinion is in accord with other circuits regarding the standard of proof for a plaintiff bringing a § 510 action, the petition for certiorari should be denied.

COUNTERPOINT III

BECAUSE EMPLOYERS MUST HAVE FLEXIBILITY WITH RESPECT TO EMPLOYEE BENEFITS, PUBLIC POLICY DICTATES THAT THE PETITION FOR CERTIORARI SHOULD BE DENIED.

What McGann is suggesting under the guise of a public policy argument is that the federal courts should freeze health care insurance for AIDS so that health insurance for this disease can never be reduced or terminated. Such a suggestion violates the very essence of ERISA and would be a tremendous disincentive to employers to offer any health care insurance when the insurance can never be changed.

Because of unpredictable economic factors, such as inflation and the variable costs associated with health care, the Fifth Circuit recognized that employer control over

health insurance benefits must exist without restraint. *McGann,* 946 F.2d at 407.

The judicial reluctance to interfere with benefit plan modification or proscribe plan termination is founded squarely upon the congressional intent which created ERISA. Congress intended for the terms of welfare benefits to be left up to the employer. *McGann,* 946 F.2d at 407. Creating, modifying, and terminating employee benefit plans were concepts addressed by Congress when it enacted ERISA. Congress particularly recognized that employers offering medical insurance must have the ability to terminate or modify their plans so that the benefit plan could survive unpredictable economic forces. *Moore v. Metropolitan Life Ins. Co.,* 856 F.2d 488, 492 (2d Cir. 1988). If employers had no flexibility to maintain the solvency of the plan, "substantial disincentives for even offering such plans would be created." *Id.*

Modification of employee benefits may present a hardship to some members of the plan, but the overall benefit is realized by the majority when the plan remains solvent. This was the outcome intended by Congress and recognized by the Second Circuit in *Moore* and the Fifth Circuit in the case at bar. *McGann,* 946 F.2d 401, 407-08.

McGann's public policy argument, if effectuated, will have a devastating effect on group health insurance. The Fifth Circuit appropriately recognized the unfortunate outcome freezing AIDS benefits may have. If the federal courts can freeze health insurance benefits or determine which health insurance benefits must be offered, employers may choose not to offer any health benefits in the first place. The petition for certiorari should, therefore, be denied.

COUNTERPOINT IV

BECAUSE AN EMPLOYER HAS AN ABSOLUTE RIGHT TO ALTER THE TERMS OF AN EMPLOYEE BENEFIT PLAN, BARRING CONTRACTUAL PROVISIONS TO THE CONTRARY, McGANN'S § 510 CLAIM IS MOOT.

Because H & H had an absolute right to modify or terminate the plan, the District Court held that McGann's § 510 claim need not be addressed. The Fifth Circuit, however, took an opposite approach and chose to address the § 510 claim and not the issue concerning the employer's absolute right to terminate the plan.[4] Although the Fifth Circuit did not address this issue, the District Court was correct. Termination of the plan was lawfully exercised. Therefore, the § 510 claim is moot and need not be reviewed by this Court.

The District Court's rationale is in accord with the established principle that employers have the right to amend or terminate welfare benefit plans so long as such right does not violate the terms and conditions of the benefit plan.[5] The only standard governing the termination or modification of the plan is whether the termination and modification was done in accordance with the plan.

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4. "As noted, the district court stated as one ground for its decision that an employer has an absolute right to alter the terms of an employee benefits plan, barring contractual provisions to the contrary [citations omitted]. We do not find it necessary to decide this question." *McGann*, 946 F.2d at 406 n.8.

5. *Alday v. Container Corporation of America*, 906 F.2d 660, 663 (11th Cir. 1990); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988); *Musto v. American General* Corp., 861 F.2d 897, 912 (6th Cir. 1988), *cert. denied*, __U.S.__ (1989); *Anderson v. John Morrell & Co.*, 830 F.2d 872, 876 (8th Cir. 1987); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350, 1351-52 (8th Cir. 1985); and *Tackitt v. Prudential Ins. Co. of America*, 758 F.2d 1572, 1575 (11th Cir. 1985).

Absent a departure from the terms of the plan, ERISA will not create liability on the part of the employer who changes the kind of health plan it provides to employees. *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350, 1352 (8th Cir. 1985).

Because the only standard to review termination and modification is compliance with the terms of the plan, the intent underlying a decision to modify or terminate, whether ill-motivated or altruistic, is not subject to court review. Whenever an employer makes a decision to establish, amend, or terminate an employee benefit plan, the motivation behind those actions is irrelevant. See *Musto v. American General Corp.*, 861 F.2d 897, 912 (6th Cir. 1988), *cert. denied*, ____U.S.____ (1989). ERISA is concerned with the administration of the plan after it has been established rather than mandating its establishment and requiring that it be continued indefinitely without reduction of benefits. *Id.; Viggiano v. Shenango Div. of Anchor Hocking*, 750 F.2d 276, 279 (3d Cir. 1984).

In a virtually identical case as the case at bar, the same determination was reached; the employer was not proscribed from terminating an insurance plan which provided benefits for health insurance for AIDS, that were neither vested nor accrued, and instituting a new plan with a cap on AIDS related payments. *Owens v. Storehouse*, 773 F. Supp. 416 (N.D. Ga. 1991). An absolute right existed to modify the health insurance benefits. *Id.* In McGann's case as well, the District Court was correct in ruling that an absolute right to modify the plan existed.

Although General American does not disagree with the analysis of the Fifth Circuit when it chose to evaluate McGann's § 510 argument, the analysis, albeit correct,

was not necessary inasmuch as the modification of the employee benefit plan was carried out in accordance with the summary plan description. Because H & H had an absolute right to modify the plan, the matter should not be reviewed.

COUNTERPOINT V

A NONEMPLOYER CANNOT BE HELD LIABLE FOR A § 510 VIOLATION.

In the alternative, without waiving the foregoing, another basis for no review being necessary by the United States Supreme Court is that McGann cannot sue General American under § 510 because General American did not employ McGann.[6] A § 510 claim does not apply to a nonemployer. *Rollo v. Maxicare of Louisiana*, 698 F. Supp. 111 (E.D. La. 1988); *cf. Rogers v. Jefferson-Pilot Life Ins. Co.*, 883 F.2d 324, 326 (4th Cir. 1989).

The statutory language, legislative history, and case law all make clear that § 510 was designed to protect the "employment relationship." Without this relationship, there can be no § 510 claim.

Statutory Language:

Section 510 of ERISA, 29 U.S.C. § 1140, makes it "unlawful for any *person* to discharge, fine, suspend, expel, discipline, or discriminate against a participant . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under

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6. Although this issue was raised before the District Court and the Fifth Circuit, neither chose to address it. The Fifth Circuit did not decide the issue because of its disposition of the case on other grounds. *McGann*, 946 F.2d at 403-04 n.3.

the plan. . . ." [emphasis added]. At first glance, the reference to "any person" may appear to give the statute global application to all defendants; however, application to non-employers was not intended by Congress and is not evidenced by the statutory language within § 510 which uses verbs which anticipate improper conduct by the employer (e.g. discharge, fine, suspend, expel, discipline, or discriminate against).

Although the term "corporation" is included within the meaning of the word "person" for purposes of § 510, the term "insurer" is not within the definition.[7] Given the congressional intent to prohibit employers from discriminating against employees, surely the inclusion of "corporation" in the definition of "person" was addressing the employer/corporation and not the insurer/corporation, especially since § 510 seeks to curtail conduct which directly alters the employer/employee relationship and the insurer cannot directly, nor fundamentally, alter the plan participant's employment relationship.

Legislative History:

The congressional purpose underlying § 510 is to protect the employer/employee relationship. Employers have a financial incentive to discharge employees and executives who may become vested in substantial pension benefits. 119 Cong. Rec. 30374, *reprinted* in Legislative History at 1774-75. See also 119 Cong. Rec. 30044, *reprinted in* Legislative History at 641. To prevent employees from being terminated, Congress designed § 510 as a safeguard.

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7. "The term 'person' means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C. § 1002(9).

Caselaw:

A fundamental prerequisite to a § 510 action is an allegation that the employer/employee relationship, and not merely the plan, was changed in some discriminatory fashion. *Deeming v. American Standard, Inc.*, 905 F.2d 1124, 1127 (7th Cir. 1990). Without an employer/employee relationship between the parties, a § 510 claim cannot exist. *Rollo v. Maxicare of Louisiana, Inc.*, 698 F. Supp. 111 (E.D. La. 1988). The Court in *Rollo* denied a motion for leave to amend a complaint to add a cause of action under § 510 against a doctor and a health maintenance organization which administered an employee health insurance plan. The court held that § 510 was not intended to apply to nonemployers, since the policy thrust of the statute targets the employment relationship out of which employee benefits arise, and because the section "speaks of conduct which, functionally, can only be completed by one who is an employer of the aggrieved person." *Id.* at 114.

In support of its holding, the *Rollo* court relied upon *West v. Butler*, 621 F.2d 240 (6th Cir. 1980), in which the Sixth Circuit affirmed the dismissal of a discrimination claim by pension fund trustees who sought to enjoin the defendants from picketing coal mines with which the fund had collective bargaining agreements. Since many employees refused to cross the picket lines, mine production fell and the fund contributions tied to coal production dropped. Hence, the plaintiffs argued that the defendant-picketers were interfering with the miners' pension benefits. Holding that the plaintiffs had not stated a cause of action under § 510, the Sixth Circuit noted that § 510 was "aimed primarily at preventing unscrupulous employers from discharging or harassing their employees in

order to keep them from obtaining vested pension rights." *Id.* at 245. The Sixth Circuit concluded that to violate § 510, discrimination must substantially affect the employment relationship that gives rise to an individual's pension rights. *Id.* at 245-46. The Sixth Circuit found § 510 inapplicable to the defendant-picketers since, unlike the employer, the picketers were not in a position to disrupt the employment relationship directly. At worst, the picketers could prevent an employee from going to work. Even though *West* did not hold that only employers may be held liable under § 510, it expressly stated that § 510 only addresses conduct which fundamentally changes the employer/employee relationship.

Similarly, *Adams v. Koppers Co.*, 684 F. Supp. 399 (W.D. Pa. 1988), held that a pension plan was not a proper defendant under a § 510, 29 U.S.C. § 1140 claim. The "legislative history indicates that § 1140 was directed at employment decisions, which would not normally be under the control of the plan." *Id.* at 401.

In this case, the evidence did not show any suggestion that McGann's position had been terminated or jeopardized by either General American or H & H. McGann did not allege any interference by General American of his employment relationship with H & H. Even if McGann had alleged that General American had suggested that McGann retire or leave his position, that would not be the type of direct interference with the employer/employee relationship which would have given rise to a § 510 cause of action. *Swanson v. U. A. Local Pension Plan*, ___ F. Supp. ___ (W.D.N.Y. 1991).

As a practical matter, an insurance company is not in the posture to jeopardize the employer/employee relationship. Therefore, under the undisputed facts of this case,

McGann's allegation under § 510 claim directed against General American is not actionable because General American has never been McGann's employer and General American took no action to jeopardize McGann's employment relationship with H & H. The writ of certiorari should be denied because McGann cannot state a claim against General American.

COUNTERPOINT VI

CONSPIRACY TO DISCRIMINATE IS NOT A CAUSE OF ACTION UNDER ERISA.

Without waiving the preceding argument, in reality, McGann did not plead a true § 510 violation against General American. Instead, McGann alleged that General American, in conjunction with H & H and Brook Mays, conspired to violate his rights under § 510. McGann alleged, "Defendants by conspiring together to change Plaintiff's insurance coverage acted for the purpose of interfering with Plaintiff's attainment of rights to which he was entitled or may become entitled" (Br. Opp. App. A p. A8). This "conspiracy to discriminate" allegation does not state a cause of action under ERISA. *Phillips v. Amoco Oil Co.*, 614 F. Supp. 694, 712 (N.E. Ala. 1985), *affirmed*, 799 F.2d 1464 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987). In *Phillips*, employees sued Amoco and others on § 510 theories because their employee benefits had been adversely affected by Amoco's sale of a company. The Court in *Phillips* recognized that a Plaintiff's claim for conspiracy to violate ERISA fails to state a cause of action under ERISA; the provisions of ERISA focus on the underlying wrong, rather than any conspiracy to commit the wrong. *Id.* at 22. Without admitting that McGann has the right to assert a § 510 claim

against General American, McGann's allegation that General American conspired against him to violate § 510 does not state a cause of action against General American upon which relief may be granted as a matter of law. This matter therefore should not be reviewed by the United States Supreme Court.

CONCLUSION

For the reasons stated above, the Fifth Circuit's decision and application of ERISA are consistent with the congressional intent underlying ERISA and the opinions of other circuits. The ruling by two courts upon reviewing the record that McGann failed to create a genuine issue of fact under Rule 56 does not present an important question of federal law unsettled by this Court, one in conflict with applicable decisions of the circuit courts or a case otherwise calling for the supervision of the Supreme Court of the United States. The petition for writ of certiorari should be denied.

Dated: March 6, 1992
Houston, Texas

Respectfully submitted,

DUNN, KACAL, ADAMS, PAPPAS & LAW

RICHARD M. LAW
MARY HUNNELL SMITH
2929 Allen Parkway, Suite 2600
Houston, Texas 77019
(713) 529-3992

Counsel for Respondent General American Life Insurance Company

APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-89-1995
JURY DEMAND
JOHN McGANN,
Plaintiff

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendants

Filed August 2, 1989

Jesse E. Clark, Clerk

PLAINTIFF'S FIRST AMENDED COMPLAINT

JOHN McGANN, Plaintiff, complains of H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY, Defendants, as follows:

INTRODUCTION

1. Plaintiff brings this action for violation of his rights under § 1140 of the Employee Retirement Income Security Act of 1974 (hereafter "ERISA"), 29 U.S.C. § 1001 *et seq*. Plaintiff alleges that Defendants have discriminated against him for exercising rights to which he is entitled under the provisions of an employee benefit plan, and for the purpose of interfering with the attainment of rights to which Plaintiff may become entitled under such plan, by wrongfully changing the employee

benefits coverage provided to Plaintiff through his employment with Defendant H & H MUSIC COMPANY and provided through BROOK MAYS MUSIC COMPANY. Because of the continuing and irreparable nature of the resulting injury, Plaintiff seeks expedited preliminary injunctive relief from this Court restoring to him all prior benefits. Plaintiff also seeks, pursuant to § 1140 of ERISA, reasonable attorneys' fees and costs, all benefits due to him under the terms of his prior benefit plan, and permanent injunctive relief restraining Defendants from further discriminating against Plaintiff.

2. Plaintiff also invokes this Court's power of pendant jurisdiction and brings a claim pursuant to § 501(1) of the Texas Commission on Human Rights Act, V.A.T.S. art. 5221k (1987). Plaintiff alleges that Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY discriminated against him with regard to his employment-related benefits on account of his handicap, Acquired Immune Deficiency Syndrome (hereafter "A.I.D.S"). Pursuant to the Texas Commission on Human Rights Act, Plaintiff seeks injunctive relief, costs and attorneys' fees, and compensatory damages.

3. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21, § 4(7)(b), prohibiting "unfair discrimination" in the benefits or terms and conditions in any contract of health insurance or payment of benefits thereunder. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY discriminated against him by refusing to insure or refusing to continue to insure Plaintiff due to his handicap. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16, Plaintiff seeks injunctive relief, actual damages, court costs, and attor-

neys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, *in addition,* two times the amount of actual damages.

4. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21-3, entitled "Discrimination Against Handicapped Prohibited," which prohibts an insurer from discriminating against a handicapped insured by refusing to insure or refusing to continue to insure a handicapped individual. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY unfairly discriminated against him by initiating a cessation of coverage. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, *in addition,* two times the amount of actual damage.

5. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 *et seq.*, the Texas Deceptive Trade Practices—Consumer Protection Act, which prohibits "false, misleading, or deceptive acts or practices in the conduct of any trade or commerce." Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, in providing its sērvice as group insurer, committed false and deceptive acts by inducing certain acts or events so as to cause itself to change from insurer of the medical/hospitalization policy of Defendants

H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY to merely becoming the administrator of such policy. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of facts finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed unconscionable acts, or acts in violation of V.A. T.S. Insurance Code, art. 21.21, the Court shall award not more than three times the amount of actual damages in excess of $1,000.00.

6. Plaintiff also invokes the court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 *et seq.*, the Texas Deceptive Trade Practices—Consumer Protection Act, which prohibits "false, misleading, or deceptive acts or practices in the conduct of trade or commerce." Plaintiff alleges that Defendant employer, H & H MUSIC COMPANY, as fiduciary for the medical/hospitalization policy for employee JOHN McGANN, your Plaintiff, committed fraudulent acts by its intent to conceal from the Plaintiff, through a concerted effort with the other defendants, that the medical/hospitalization group policy on which Plaintiff would rely to obtain his medically necessary treatments, would be modified to eliminate medical/hospitalization benefits. Plaintiff relied upon Defendant H & H MUSIC COMPANY to act as a proper fiduciary, and Plaintiff's reliance upon Defendant H & H MUSIC COMPANY has caused Plaintiff immense injury. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant H & H MUSIC COMPANY knowingly committed unconscionable acts, or acts in violation of V.A.T.S. BUS. & COM.

CODE § 17.50, the Court shall award not more than three (3) times the amount of actual damages in excess of $1,000.00.

7. Plaintiff also brings causes of action for breach of contract, and related state law claims against Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, arising out of the breach of fiduciary duties by Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY.

JURISDICTION

8. This Court has jurisdiction of this action under § 1132(e) of ERISA, 29 U.S.C. § 1001 *et seq.*, and under its power of pendant jurisdiction to hear Plaintiff's state law claims. The state law claims and the federal law claims derive from a common nucleus of operative fact.

PARTIES

9. Plaintiff JOHN McGANN is a resident of Houston Harris County, Texas, and a citizen of the United States. He has been employed by Defendant H & H MUSIC COMPANY since 1982.

10. Defendant H & H MUSIC COMPANY is a Texas Corporation, doing business as a music store in Houston, Harris County, Texas. Its registered agent is Clyde W. Reynolds, who may be served with process at 1211 Caroline, Houston, Harris County, Texas 77002.

11. Defendant BROOK MAYS MUSIC COMPANY is a Texas corporation, doing business in Houston, Harris County, Texas. Its registered agent is William C. Everitt, who may be served with process at 644 West Mockingbird, Dallas, Dallas County, Texas 75247.

12. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY is a Missouri corporation, doing business in Texas. Its registered agent for service is Robert E. Jackson, who may be served with process at 1200 Summit Avenue, Suite 500, Fort Worth, Tarrant County, Texas 76102.

FACTS

13. At all relevant times, Defendant H & H MUSIC COMPANY was an employer engaged in an industry or activity affecting commerce within the meaning of 29 U.S.C. § 1002(5), (11), and (12) and § 2.01(5) of V.A.T.S. art. 5221k (1987).

14. At all material times, Plaintiff JOHN McGANN was an employee of Defendant H & H MUSIC COMPANY within the meaning of 29 U.S.C. § 1002(6) and § 2.01(4) of V.A.T.S. art. 5221k.

15. Defendant H & H MUSIC COMPANY's employee benefits plan, including but not limited to its group medical/hospitalization benefits plan, is an employee benefit plan within the meaning of 29 U.S.C. § 1002(3) and 29 U.S.C. § 1140, and whose Plan Administrator is Defendant BROOK MAYS MUSIC COMPANY.

16. Plaintiff JOHN McGANN was and is a participant in Defendant BROOK MAYS MUSIC COMPANY's employee benefits plan within the meaning of 29 U.S.C. § 1002(7) and 29 U.S.C. § 1140.

17. Plaintiff JOHN McGANN has been employed by Defendant H & H MUSIC COMPANY since 1982, and

thereafter covered by Defendant BROOK MAYS MUSIC COMPANY's Group Medical Care Plan.

18. In December 1987, Plaintiff JOHN McGANN was diagnosed as having A.I.D.S. This fact was well known by all defendants.

19. On August 3, 1988, Defendant BROOK MAYS MUSIC COMPANY announced that its Group Medical Care Plan covering Defendant H & H MUSIC COMPANY's employees, and wherein Defendant GENERAL AMERIAN LIFE INSURANCE COMPANY had been insurer, was cancelled effective August 1, 1988, and that the substituted group medical/hospitalization policy would be self-insured, with Defendant GENERAL LIFE INSURANCE COMPANY as administrator only. Benefits payable for A.I.D.S-related claims were modified from a lifetime maximum covered expense of $1,000,-000.00 to only $5,000.00, and therefore potentially excluded $955,000.00 in insured expenses available to Plaintiff JOHN McGANN.

20. On October 12, 1988, Plaintiff JOHN McGANN filed a complaint with the Texas Commission on Human Rights, alleging that he was discriminated against by Defendant H & H MUSIC COMPANY on account of his handicap, A.I.D.S. (TCHR Complaint No. 3890030). On or about April 10, 1989, he received his "notice of Right to File a Civil Action" from the Texas Commission on Human Rights.

21. Plaintiff believes that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY acted in conspiracy with Defendant H & H MUSIC COMPANY and Defendant BROOKS MAYS MUSIC COMPANY to violate Plaintiff's rights under ERISA and to discrimi-

nate against Plaintiff on account of his handicap, A.I.D.S. Prior to August 1, 1988, Plaintiff was fully insured for his handicapping condition of A.I.D.S. for the maximum expense of $1,000,000.00. On August 1, 1988, the Defendants acted in concert in conspiring to discriminate against Plaintiff JOHN McGANN. Defendants schemed so that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's obligations to Plaintiff JOHN McGANN would cease by termination of the General American policy and by imposition of an H & H Music Company/Brook Mays Music Company self-insured plan that limited the obligations of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to no more than $5,000.00 for claims related to Plaintiff's handicapped condition, but, again, whereby Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY remained administrator of the policy and no longer liable.

22. Defendants' wrongful actions toward Plaintiff have caused Plaintiff considerable mental suffering. Medical studies have consistently shown that increased anxiety levels, like that induced in Plaintiff by Defendants' actions, increase the likelihood of repeated infections and further worsen existing infections and medical problems of A.I.D.S. patients.

FIRST CAUSE OF ACTION

Interference with Protected Rights Under ERISA

23. Defendants, by conspiring together to change Plaintiff's insurance coverage, acted for the purpose of interfering with Plaintiff's attainment of rights to which he was entitled or may have become entitled under the employee benefit plan of Defendant H & H MUSIC

COMPANY or under ERISA, 29 U.S.C. § 1001 *et seq.* Defendant's actions thus constitute a violation of § 1140 of ERISA. As a result of Defendants' conspiratorial actions, Plaintiff has lost benefits of employment, suffered mental anguish, and been forced to employ attorneys in order to vindicate his rights and to obtain other appropriate equitable relief. In addition, Plaintiff has been forced to accept an inferior medical hospitalization insurance plan, which in essence is of little or no value, as it conveniently exempts those treatments that are necessary for maintenance of Plaintiff JOHN McGANN's health.

SECOND CAUSE OF ACTION

Texas Commission on Human Rights Act

24. Defendant H & H MUSIC COMPANY discriminated against Plaintiff JOHN McGANN by changing his insurance coverage on account of his handicap, A.I.D.S., in violation of § 5.01(1) of the Texas Commission on Human Rights Act, V.A.T.S. art. 5221k (1987). As a result, Plaintiff has lost benefits of employment, suffered mental anguish, and has had to employ attorneys in order to vindicate his rights.

THIRD CAUSE OF ACTION

Violation of V.A.T.S. Insurance Code, Art. 21.21

25. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, by conspiring together with Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to change Plaintiff's insurance coverage, sought to unfairly discriminate in the benefits or terms and conditions of their health insurance plan effective prior to August 1, 1988. De-

fendant GENERAL AMERICAN LIFE INSURANCE COMPANY's actions constitute a violation of V.A.T.S. Insurance Code, art. 21.21, *et seq.* As a result of their acts, Plaintiff has lost benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition.

FOURTH CAUSE OF ACTION

Violation of State Insurance Laws Protecting Handicapped

26. Defendants, by conspiring together to change Plaintiff's insurance coverage, sought unfairly to discriminate against Plaintiff, a handicapped person, by refusing to insure, or refusing to continue to insure, Plaintiff. As a result of these acts, Plaintiff has been damaged by the loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition pursuant to V.A.T.S. Insurance Code, art. 21.21-3.

FIFTH CAUSE OF ACTION

Deceptive Trade Practices by Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY

27. Defendants, by conspiring together to change Plaintiff's insurance coverage, caused Plaintiff to be damaged by Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's false and deceptive acts by causing Plaintiff's existing medical policy to pre-

maturely terminate. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's acts were knowingly committed in violation of V.A.T.S. BUS. & COM. CODE § 1741 *et seq.;* and, accordingly, Plaintiff has been damaged by the untimely loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his medical needs related to his handicapped condition.

SIXTH CAUSE OF ACTION
Deceptive Trade Practices by
Defendants H & H MUSIC COMPANY
and BROOK MAYS MUSIC COMPANY

28. By conspiring together to change Plaintiff's insurance coverage, Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY caused Plaintiff to be damaged by their false and deceptive acts, by their efforts to conceal information that they were purposely modifying their insurance policies to eliminate medical/hospitalization benefits that they knew were necessary to sustain Plaintiff. As a further direct and proximate result of this breach of duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of the false and deceptive acts of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

SEVENTH CAUSE OF ACTION
Breach of Duty Created by Agency

29. Defendant H & H MUSIC COMPANY acted as

Plaintiff's agent for the purpose of doing generally what was needed to obtain and preserve insurance coverage for employees of H & H MUSIC COMPANY and owed to Plaintiff the duty owed by an agent to a principal. Defendant H & H MUSIC COMPANY breached this duty to Plaintiff by failing to notify Plaintiff, as obligated by such agency relationship, of the impending cessation of his needed medical/hospitalization benefits related to his known handicap. As a result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

STATEMENT OF IRREPARABLE HARM

30. Plaintiff requests an expedited hearing on his request for preliminary injunctive relief, as Plaintiff will suffer irreparable injury unless this Court immediately orders Defendants to restore to Plaintiff his prior health insurance coverage, and restrains Defendants from further unlawful discrimination against Plaintiff. Defendants' unlawful actions are depriving Plaintiff of appropriate and necessary health insurance, and causing him to fear imminent financial and emotional helplessness. Such threatened injuries clearly outweigh any damage the requested injunction might cause to Defendants' interests of the public coincide with those of Plaintiff. Plaintiff has no adequate remedy at law due too the daily worsening of Plaintiff's financial and emotional states.

31. Plaintiff hereby demands a JURY on all issues triable by jury.

Wherefore, Plaintiff requests the following relief:

1. that, following an expedited hearing a preliminary injunction be issued to restore to Plaintiff his former insurance benefits; and that Plaintiff be granted a permanent injunction upon trial of this case;

2. that Plaintiff recover his compensatory damages, including the value of his lost insurance coverage, valued at NINE HUNDRED FIFTY-FIVE THOUSAND AND NO/100 ($955,000.00) DOLLARS and, additionally, such other actual damages as shall be proved at trial resulting from Defendants' unlawful conduct;

3. that Plaintiff, in addition to recovering actual damages, recover additional damages of TWO MILLION NINE HUNDRED EIGHTY-FIVE THOUSAND AND NO/100 ($2,985,000.00) DOLLARS, as pleaded should the trier of fact find the requisite knowledge in the commission of Defendants' conspiratorial scheme;

4. that Plaintiff recover damages for his mental anguish resulting from Defendants' tortious and discriminatory conduct;

5. that Plaintiff recover punitive damages due to Defendants' malice and bad faith and as justified by the evidence at trial in a sum in excess of ONE MILLION AND NO/100 ($1,000,000.00) DOLLARS;

6. that Plaintiff be awarded prejudgment and post-judgment interest at the maximum legal rate;

7. that Plaintiff recover reasonable attorneys' fees; and

8. that Plaintiff be awarded his costs of court and any other relief to which he proves himself entitled.

Respectfully submitted,

HELEN BRATTIN
Helen Brattin
Southern District ID No. 5072
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

DONALD L. SKIPWITH
Southern District ID No. 1841
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

ATTORNEYS FOR PLAINTIFF

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Civil Action No. H-89-1995

JOHN McGANN,
Plaintiff

v.

H & H MUSIC COMPANY,
BROOK MAYS MUSIC COMPANY, AND
GENERAL AMERICAN
LIFE INSURANCE COMPANY,
Defendants

VERIFICATION

COUNTY OF HARRIS)
)
STATE OF TEXAS)

BEFORE ME, the undersigned authority on this day personally appeared JOHN McGANN, who, being by me duly sworn, made the following statements:

> "My name is JOHN McGANN, and I am the Plaintiff in this cause. I am aware of the factual allegations of Plaintiff's First Amended Complaint, and all such factual allegations therein are true and correct."

/s/ JOHN McGANN
John McGann

SWORN TO AND SUBSCRIBED BEFORE ME this 25th day of July, 1989.

/s/ AUDREY L. SEAWRIGHT
Notary Public in and for
the State of Texas

/s/ AUDREY L. SEAWRIGHT
Printed Name of Notary Public
My commission expires: 7/20/92

APPENDIX B

(Filed January 16, 1990, Jesse E. Clark, Clerk)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-89-1995

JOHN McGANN,
Plaintiff

v.

H & H MUSIC COMPANY,
BROOK MAYS MUSIC COMPANY, AND
GENERAL AMERICAN
LIFE INSURANCE COMPANY,
Defendants

DEFENDANT GENERAL AMERICAN
LIFE INSURANCE COMPANY'S
MOTION FOR FINAL SUMMARY JUDGMENT

TO THE HONORABLE JUDGE OF
SAID COURT:

COMES NOW, General American Life Insurance Company ("General American"), a named Defendant herein, and files this its Motion for Summary Judgment and in support thereof would show the court as follows:

I.

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, this Defendant would show that there is no material issue of fact and that Defendant, General American, is entitled to judgment as a matter of law. This Motion for Summary Judgment is based upon the pleadings herein, the affidavit of Albina Kraml League, at-

tached hereto as Exhibit "A" and incorporated herein by reference, and Exhibits "A-F" attached to Defendants, H & H Music Company and Brook Mays Music Company's Motion for Final Summary Judgment, incorporated herein by reference as well.

II.

Plaintiff herein alleges in his First Amended Complaint that H & H Music Company ("H & H"), Brook Mays Music Company ("Brook Mays"), and General American have violated the provisions of the Employee Retirement Income Security Act. 29 US.C. § 1001 *et seq.* ("ERISA"). Additionally, Plaintiff alleges that General American violated various provisions of Texas State law including:

(a) The Human Rights Act, V.A.T.S. Article 5221k (1987);

(b) V.A.T.S. Insurance Code Article 21.21;

(c) V.A.T.S. Insurance Code Article 21.21-3; and

(d) V.A.T.S. Business and Commerce Code § 17.41 *et seq.*, more commonly known as the Texas Deceptive Trade Practices—Consumer Protection Act ("DTPA").

III.

FACTS

All of the alleged facts as contained in Plaintiff's First Amended Complaint, for the purpose of this Motion, should be taken as true. The salient facts that relate to the substance of this Motion are summarized herein.

Plaintiff John McGann has been employed by Defendant H & H since 1982. During his employment at H & H, Plaintiff has been covered by Defendant Brook Mays' group medical plan. A true and correct copy of the Group Insurance Plan in effect from August 1, 1987, through July 31, 1988, is attached as Exhibit "A" in the Motion for Final Summary Judgment filed by H & H and Brook Mays and is incorporated herein by reference for all purposes. A copy of the Summary Plan Description Booklet ("SPD") associated with the plan and distributed to employees of H & H is attached as Exhibit "B" in the Motion for Final Summary Judgment filed by H & H and Brook Mays and is incorporated herein by reference for all purposes.

Plaintiff was diagnosed as having acquired immune deficiency syndrome ("AIDS") in December 1987. Plaintiff alleges that his diagnosis was known by all Defendants named herein.

IV.

On July 28, 1988, Brook Mays announced that the medical care plan covering H & H employees would terminate on August 1, 1988, and that a new group medical care plan would take effect. Brook Mays' announcement was made in writing and the writing is attached as Exhibit "C" in the Motion for Final Summary Judgment filed by H & H and Brook Mays and is incorporated herein by reference for all purposes. The change effected by Brook Mays was from a fully insured group medical plan to a self insured plan. General American and Brook Mays entered into an Administrative Services Agreement with respect to Brook Mays' new self insured medical plan. The Administrative Serv-

ices Agreement is attached as Exhibit "D" in the Motion for Final Summary Judgment filed by H & H and Brook Mays and is incorporated herein by reference for all purposes. Pursuant to the terms of the Agreement, General American received administrative services fees to administer and pay claims. Since Brook Mays' new plan was self insured no policy regarding medical benefits was issued to Brook Mays by General American. The SPD provided to all H & H employees contained the medical benefits offered under the new plan. Under Brook Mays' new plan, benefits payable for AIDS related claims were a lifetime maximum covered expense of FIVE THOUSAND AND NO/100 DOLLARS ($5,000.00).

Plaintiff alleges that all Defendants herein named conspired to violate Plaintiff's rights under ERISA and to discriminate against Plaintiff because he has acquired AIDS. The essence of Plaintiff's complaint is that Defendants did not have the legal right to change the Medical Benefits Plan offered to Plaintiff by H & H and Brook Mays once Plaintiff was diagnosed as having AIDS.

V.

PREEMPTION OF STATE LAW CLAIMS UNDER ERISA

The issue of the preemption of Plaintiff's state law claims has been taken up by the Court in the Motions to Dismiss and Answers filed by all Defendants herein named in this cause. Defendant General American reurges the position set forth in the Motions to Dismiss and Answers as the basis for dismissing all of Plaintiff's state law claims. As previously briefed for the Court,

there is no basis in litigation governed by ERISA for any causes of action under the Texas Insurance Code and the Texas Deceptive Trade Practices Act as a matter of law.

VI.

TERMINATION BY EMPLOYER OF GROUP BENEFIT PLAN

The first issue raised in this cause of action is whether Defendants H & H and Brook Mays had a legal right to terminate their group benefit plan as to all of their employees. The termination of the plan necessarily terminated Plaintiff's rights to any benefits under the plan. The termination of the plan terminated any rights the Plaintiff had to receive benefits under the plan because the plan would no longer be in existence to provide those benefits after its termination. The termination of the benefit plan was expressly provided for in the Summary Plan Description Booklet ("SPD") associated with the plan and distributed to all Defendant H & H employees. The SPD provides in pertinent part that "the plan sponsor may terminate or amend the plan at any time or terminate any benefit under the plan at any time." *See* Exhibit "B" to H & H and Brook Mays' Motion for Final Summary Judgment, incorporated herein by reference.

The question of whether ERISA prohibits the termination of group medical benefit plans has been addressed in *Hamilton v. The Travelers Insurance Company*, 752 F.2d 1350 (8th Cir. 1985). In *Hamilton*, an employee brought a declaratory judgment action against his employer and his group health insurer for a termination of coverage for expenses incurred by the employee

in connection with his son's eye injury. The employee sought to establish that his employee and group health insurer were required to provide insurance benefits for the expenses incurred in treating the son's injury after the insurance policy was terminated. The Plaintiff in *Hamilton* alleged violations of ERISA in the termination of the policy. The Court found no ERISA violations for the termination of the insurance policy.

In reaching its decision, the Court pointed out that the Summary Plan Description Booklet which was distributed to Hamilton explicitly provided that the employer, "as the plan's administrator, 'may terminate . . . the plan in whole or in part at any time, subject to the applicable provisions of the group insurance policies.' " *Hamilton,* 752 F.2d at 1351. The Court found that on the basis of the SPD the employer "was under no contractural obligation to refrain from terminating the plan." *Id.* Additionally, the Court agreed with the District Court's conclusion that " 'ERISA does not create liability on the part of the employer who changes the kind of health plan provided to employees where no contract prohibits or prevents such change.' " *Id.* at 1351-52. The Court then concluded that both the employer and the insurance company were entitled to judgment as a matter of law because ERISA did not proscribe their actions in terminating the medical benefits plan.

VII.

In the present case, it is undisputed that H & H and Brook Mays terminated their group plan with General American on July 31, 1988. The contractual documents associated with the plan, however, specifically reserved to H & H and Brook Mays the right to terminate

the plan. According to the Affidavit of Albina Kraml-League, which is attached hereto as Exhibit "A" and is incorporated herein by reference for all purposes, H & H neither needed nor obtained the approval of General American to terminate the fully insured benefits plan and substitute a self insured plan in its place. Since the actions of H & H and Brook Mays in terminating the plan were not violative of ERISA, as indicated by the *Hamilton* decision, the lack of participation on the part of General American in termination of the plan is clearly not a violation of ERISA.

VIII.

LACK OF VESTING IN PLAINTIFF OF MEDICAL BENEFITS

The second issued raised in this cause is whether the H & H and Brook Mays' medical benefits plan was not terminable by reason of the fact that the benefits under the plan vested in Plaintiff. In dealing with the vesting requirements of ERISA, Courts distinguish group insurance plans from retirement plans *Musto v. American General Corporation,* 861 F.2d 897 (6th Cir. 1988); *Moore v. Metropolitan Life Insurance Company,* 856 F.2d 488 (2nd Cir. 1988). In *Musto,* retirees brought a class action against a former employer under ERISA challenging changes in medical insurance coverage and seeking to block changes in spousal pension plan benefits. Distinguishing group insurance plans from retirement pension plans, the Court held that ERISA gives employees vested non-terminable rights in retirement plans but not in group insurance plans. *Musto,* 861 F.2d at 901. Since automatic vesting of benefits does not occur in welfare benefit plans, the rights of plan

participants are determined by the actual language of the plan documents. *Id.* at 900.

IX.

An application of the *Musto* decision to the case at bar indicates that Plaintiff's rights to benefits under the H & H and Brook Mays group benefit plan did not automatically vest in Plaintiff. Further, *Musto* indicates that since welfare plans do not automatically vest in participants the plan documents must be examined to determine whether or not vesting occurs. According to the plan documents attached as Exhibits "A" and "B" to H & H and Brook Mays' Motion for Final Summary Judgment and incorporated herein by reference for all purposes, the benefits conferred under the H & H and Brook Mays group benefit plan did not automatically vest in the plan participants. In fact, H & H and Brook Mays expressly reserved the right to terminate the plan at any time. Because Plaintiff did not have a vested right to benefits under the plan, the termination of the plan by H & H and Brook Mays was not an ERISA violation.

X.

CONCLUSION

On the basis of the foregoing, Defendant General American Life contends that no material issue of fact exists with respect to Plaintiff's claims in this cause of action. Pursuant to the group benefit plan documents, Defendants H & H and Brook Mays had an absolute right to terminate the plan and substitute a new one at any time. Additionally, General American had no power to prevent H & H and Brook Mays from terminating

the benefit plan and substituting a self insured plan. Consequently, Defendant General American is entitled to summary judgment as a matter of law.

WHEREFORE, PREMISES CONSIDERED, Defendant General American Life Insurance Company prays that the Court enter judgment in favor of Defendant and for such other and further relief, both general and special, at law or in equity, to which Defendant General American may be justly entitled.

Respectfully submitted,

/s/ RICHARD M. LAW
Federal I.D. No. 5967
Attorney in Charge

OF COUNSEL:
DUNN, KACAL, ADAMS, PAPPAS & LAW

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2929 Allen Parkway
Suite 2600
Houston, Texas 77019
(713) 529-3992
Attorneys for Defendant,

GENERAL AMERICAN LIFE
INSURANCE COMPANY

CERTIFICATE OF SERVICE

I hereby certify that on the 18th day of January 1990, a true and correct copy of the above and foregoing instrument was forwarded, pursuant to the Federal Rules of Civil Procedure, to all counsel of record by certified mail, return receipt requested and/or by hand delivery.

/s/ RICHARD M. LAW
Richard M. Law

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-89-1995
JOHN McGANN,
Plaintiff

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY and GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendants

AFFIDAVIT

STATE OF MISSOURI §
§
COUNTY OF ST. LOUIS §

BEFORE ME, the undersigned authority, on this day personally appeared ALBINA KRAML LEAGUE.

I am over the age of twenty-one years and competent to make this affidavit. I am employed as Director—Large Group Accounts Underwriting for General American Life Insurance Company, St. Louis, Missouri.

Prior to August 1, 1988, General American Life Insurance Company provided the employees of Brook Mays Music Company and H & H Music Company with a fully insured employee benefit plan, providing medical care expense insurance for employees and dependents, with a lifetime major medical maximum of $1,000,000.

As of August 1, 1988, eligible employees of the Brook Mays Music Company, and two associated companies, H & H Music Company and C & S Music Company, became insured for life and accidental death insurance only. The medical expense benefits coverage under the prior policy were cancelled and replaced by a self-insured benefits plan, which included a lifetime cap of $5,000 on benefits for AIDS. General American Life Insurance administers the self-insured benefits plan for Brook Mays Music Company, for a fee.

General American Life Insurance Company is not now, and has never been, the employer of John McGann.

H & H Music Company niether needed nor obtained the permission of General American Life Insurance Company to cancel the medical expense benefits coverage under the prior policy. H & H Music Company neither needed nor obtained the approval of General American Life Insurance Company to cancel the medical expense benefits coverage under the prior policy. H & H Music Company neither needed nor obtained the approval of General American Life Insurance Company with respect to their provisions of its new self-insured plan. General American Life Insurance Company had no power to prevent the employer from cancelling the medical expense benefits coverage under the prior policy and proceedings with a self insured plan. As a result of the employer's decision, General American Life Insurance Com-

pany, as of August 1, 1988, has not insured John McGann for medical expense benefits coverage.

General American Life Insurance Company made no representations or inducements whatsoever to H & H Music Company with reference to the employer's decision to cancel the prior medical expense benefits coverage and to initiate a self-insured benefits plan or or about August 1, 1988. Further, General American Life Insurance Company is not now nor has it ever conspired or schemed to conspire with H & H Music Company and/or Brook Mays Music Company to discriminate against John McGann with respect to withholding medical expense benefits payments.

FURTHER, affiant sayeth not,

/s/ ALBINA KRAML LEAGUE
Albina Kraml League
Affiant

SIGNED AND SWORN TO before me an January 17, 1989.

/s/ JOHN W. BATEMAN
Notary Public In And For The County Of St. Louis, State of Missouri

My commission expires 10-2-92.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Filed May 21, 1990
Jesse E. Clark, Clerk

CIVIL ACTION NO. H-89-1995
JOHN McGANN
Plaintiff

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY
Defendant

DEFENDANT, GENERAL AMERICAN LIFE INSURANCE COMPANY'S SUPPLEMENT TO MOTION FOR SUMMARY JUDGMENT

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW, GENERAL AMERICAN LIFE INSURANCE COMPANY, (General American), a named defendant herein, and files this its supplement to its Motion for Summary Judgment and in support thereof would show the Court as follows:

I.

In his original petition, Plaintiff alleges that Defendant General American violated § 510 of ERISA which provides in part:

> It shall be unlawful for any person to . . . discriminate against a participant or beneficiary . . . for the

> purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . .

29 U.S.C. § 1140 (1985)

Section 510 was "aimed primarily at preventing unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining vested pension rights." *West v. Butler,* 621 F.2d 240, 245 (6th Cir. 1980). The prohibitions in § 510 apply to employers not to plan administrators like General American. *Rollo v. MaxiCare of Louisiana, Inc.,* 698 F. Supp. 111, 113-14 (E.D. La. 1988).

Plainly, § 510 is not applicable in the instant case. The Affidavit of Albina Kraml League, (attached as exhibit "A" to Defendant General American Life Insurance Company's Motion for Final Summary Judgment) clearly indicates that Defendant General American is not Plaintiff's employer. The same situation existed in *Rollo.* The *Rollo* Court noted that § 510 was included in ERISA to guard against employers using "economic sanctions or violent reprisals" to prevent their employees from obtaining pension rights. The *Rollo* court noted that, although the Fifth Circuit had yet to rule on this precise issue, the Fifth Circuit did recognize the employer/non-employer distinction inherent in § 510. *Rollo* at 114, citing *Clark v. Resistoflex Co.,* 854 F.2d 762, 770-71 (5th Cir. 1988). Relying on *Clark,* as well as the legislative history of § 510, the District Court in *Rollo* correctly ruled that an employee cannot use ERISA § 510 to bring suit against a plan administrator.

General American has found one case, *Vogel v. Independence Federal Savings Bank,* 692 F.Supp. 587 (D. Md. 1988), where a plan administrator was sued under

ERISA § 510. The *Rollo* court expressly refused to follow the Maryland District Court's reasoning in *Vogel*, noting that it was inconsistent with the rulings of other Federal Courts, and instead relied on the legislative history and the dicta of *Clark* to reach its conclusion.

General American denies that it violated § 510 or any other section of ERISA. The evidence and existing case law clearly indicate that § 510 of ERISA does not apply to non-employers. Consequently, Defendant General American is entitled to summary judgment as a matter of law.

WHEREFORE, PREMISES CONSIDERED, Defendant, General American prays that the Court enter judgment in favor of Defendant and for such other and further relief, both general and special, at law or in equity, to which Defendant General American may be justly entitled.

Respectfully submitted,

DUNN, KACAL, ADAMS,
PAPPAS & LAW

By: /s/ RICHARD M. LAW
Richard M. Law
Federal I.D. No. 5967
2929 Allen Parkway
Suite 2600
Houston, Texas 77019
(713) 529-3992

Attorneys for Defendant,
GENERAL AMERICAN LIFE
INSURANCE COMPANY

C4

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument is being served upon all counsel of record herein in accordance with Rule 72, T.R.C.P., on this the 21st day of May, 1990.

/s/ TINA BROUSSARD, Secretary
Tina Broussard, secretary

APPENDIX D

YOUR GROUP BENEFIT PLAN

BROOK MAYS
MUSIC COMPANY

SCHEDULE PAGE

The amounts shown below are the maximum amounts payable as subsequently explained:

Employee Only Insurance Coverage:

Life Insurance	Benefit Amounts (See most recent
Accident Death and Dismemberment Insurance	certification form for amounts

Modification of Insurance Schedule

The amount of Life and Accidental Death and Dismemberment Insurance of an employee less than age 65 shall be reduced to 65% of the otherwise applicable amount on his 65th birthday.

In no event shall an employee's Accidental Death and Dismemberment Insurance be more than $20,000.00 on or after his 70th birthday.

The Accidental Death and Dismemberment Insurance may not be converted to an individual policy.

EMPLOYEE AND DEPENDENT INSURANCE COVERAGE:

MEDICAL CARE INSURANCE:

Major Medical Expense:

Major Medical Maximum $1,000,000.00

Deductible Amount—an amount of covered expenses to which the deductible requirement applies equal to the

Individual Deductible Amount of 200.00
or the Family Deduuctible Amount of.... 600.00

No part of any covered expenses for which benefits are paid or payable under the Insured Portion may be used to satisfy the Family Deductible Amount.

The family deductible must be satisfied by the employee and members of his family insured as dependents.

The Benefits Maximum and the Deductible Amount shown above are subject to adjustment in the case of a person who has received benefits or incurred charges subject to the deductible, or both, under the Schedule previously in effect.

Deductible Accumulation Period—full calendar year (or end of next calendar year when expenses are "carried over" from one calendar year to the next, as explained in the Deductible Requirement provision on a Major Medical benefits description page).

Additional Deductibles:

A) For Inpatient Hospital Confinement:

Contributions to Plan:

You pay a portion of the cost to insure yourself and your dependents.

Termination or Amendment of Plan:

The Plan Sponsor may terminate or amend the Plan at any time or terminate any benefit under the Plan at any time. If premiums are not paid to the Insurance Company the benefits issued by the Insurance Company shall terminate at the end of the Grace Period.

The Insurance Company may terminate the benefits provided under the Group Policy by giving 31 days notice to the Plan Sponsor.

If less than 100% of those employees who do not have to contribute for dependent insurance under the Group Policy or less than 75% of those employees who do have to contribute for such dependent insurance are insured for such insurance, the Insurance Company may cancel the dependent insurance by giving notice in writing to the Plan Sponsor at least 31 days prior to the date insurance will end.

Cancellation of the policy or any of its provisions may be without the consent of the Plan Sponsor or any person claiming rights or benefits under the plan. If the policy cancels or any provision ends, it shall not affect any claim which begins before the date the policy or such provision ends, subject to the terms and conditions of the policy.

APPENDIX E

H & H MUSIC COMPANY

Houston's Largest Full Time Music Company

"Since 1945"

General Offices:
11522 Old Katy Road
Houston, Texas 77043
(713) 531-9222

July 28, 1988

Dear Valued Employees;

For many years we have provided a health insurance program for you and your dependents. Over the years, this plan has been responsible for heading off financial disaster which surely would have struck many families within the H & H Music Company family had it not been for this plan.

Over the last several years, the losses for the plan have mounted steadily. Last year the plan suffered financial disaster. For every dollar that was received in premium, almost $1.50 was spent in benefit payments. When you add to this the cost of paying the claims, administering the plan, and estimating the future impact of 20% inflation in medical cost, you can see that something drastic had to be done to save the plan. A time for tough decisions has come!

With these thoughts in mind, we were faced with either dropping the plan completely or redesigning the benefits so that we hopefully can get cost back under control; therefore, effective August 1, 1988, the following changes will be made to your medical plan:

1. Increase the calendar year deductible to $300.00.
2. Increase the individual stop-loss to $10,000 per calendar year. That is, the plan will pay 80% of

covered expenses to $10,000 and then 100% of the remaining covered expenses for the balance of the calendar year.

3. Limit treatment of AIDS to $5,000 per individual lifetime.
4. Exclude all treatment for chemical dependency (drug abuse and alcoholism).
5. Add the Sanus/Passport Preferred Provider Network and Utilization Review to the program. This arrangement will essentially allow you to choose physicians and hospitals which have negotiated with us to provide medical care on a reduced pre-contract fee basis. There will be financial incentives for you to use the providers on a pre-occurrence basis. It will be a freedom of choice plan. Because of the complexities involved and the education required, there will be manager briefings for this program by the end of August or first of September. Then the managers will brief the employees on the benefits of this arrangement.
6. Increase employee contributions by $2.75 per pay day for individual coverage and $17.50 per pay day for family coverage.

While the decisions we had to make in order to save the plan were tough, we think that these changes will save the financial integrity of the plan and continue to allow it to provide financial security to the employees and their families of H & H Music Company.
Sincerely yours,

/s/ WM. C. EVERITT
William C. Everitt

APPENDIX F

SECTION II

MEDICAL CARE EXPENSE BENEFITS
as provided by
BROOK MAYS MUSIC COMPANY

MAJOR MEDICAL BENEFITS

Schedule

Important Notice

Your Medical coverage includes one or more features to help control medical care costs. Some features will affect the amount of benefits payable for your medical care. See the Cost Containment section of this plan for a further explanation.

Employee and Dependent Coverage	Amounts Applicable To You or a Dependent
Medical Care	
Lifetime Maximum For All Covered Expenses	$1,000,000
Lifetime Maximum for covered expenses incurred for:	
1. all treatment of nervous and mental conditions	$25,000
2. AIDS (Acquired Immune Deficiency Syndrome) and ARC (AIDS Related Complex)	$5,000

Deductible Amount—an amount of coverage expenses to which the Deductible Requirement applies equal to:

the Individual Deductible Amount of	$300
or the Family Unit Deductible Amount of	$900

The Family Unit Deductible must be satisfied by you and your family unit members covered as dependents.

No part of any covered expenses for which benefits are paid or payable by the plan may be used to satisfy the Family Unit Deductible Amount.

The following is Applicable When Service of a Participating Provider Are Utilized:

Services	The Plan Will Pay	Deductible Applies
1. Outpatient Diagnostic X-ray and Laboratory Service Charges incurred due to injury or illness (includes pre-admission testing)	100%	No
2. Outpatient Surgery and Anesthesia Service Charges	100%	No
3. Outpatient Hospital Charges for Medical Care, Services and supplies in connection with surgical procedures or injuries	100%	No

APPENDIX G

ADMINISTRATIVE SERVICES AGREEMENT

BY AND BETWEEN

BROOK MAYS MUSIC COMPANY
(Herein called the Client)

AND

GENERAL AMERICAN LIFE INSURANCE COMPANY
(Herein called the Service Contractor)

Whereas, the Client desires to provide benefits for certain classes of individuals in accordance with a written plan (hereinafter called "the Plan") as described in Appendix D;

Whereas, under said Plan the Client will bear all liabilities but desires that the Service Contractor provide certain services in connection with the administration and operation of the Plan;

Now, therefore, in consideration of the payments to the Service Contractor as provided in the Payment Schedule, Appendix B, and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Services

The Service Contractor will provide the services listed in Appendix A subject to modification as provided herein, for the administration and operation of the Plan; such services to be coordinated by a representative of the Service Contractor to assure effective and efficient operation of the Plan.

Section 2. Banking Arrangements

The Client shall establish a separate Benefit Plan Account in a bank as the depository for funds to be used by the Service Contractor to make payments pursuant to this Agreement and the Plan. The Client shall notify said bank that they have authorized the Service Contractor, by execution of this Agreement, to issue and accept checks drawn on such account on behalf of the Client for the purpose of payment of benefits under the Plan. It shall be the Client's responsibility to maintain funds in this Account sufficient to cover all checks validly issued by the Service Contractor's authorized employees.

Section 3. Client Reports, Records and Information

The Client hereby agrees to furnish the Service Contractor with certain necessary reports, records, and information in order to carry out its duties hereunder.

It is mutually agreed that the Service Contractor shall not be responsible for delay in the performance of its duties under this Agreement or for non-performance hereunder, if such delay or non-performance is caused or contributed to in whole or in part by the failure of the Client to promptly furnish any required information.

Section 4. Payments to the Service Contractor

For each month in which the Service Contractor performs duties pursuant to this Agreement, the Client shall make payment to the Service Contractor of amounts due within 10 days of the date of notification to the Client by the Service Contractor. The amount due shall be determined from the Payment Schedule in Appendix B. Charges for hourly services will be determined in ac-

cordance with the Service Contractor's established time allocation procedures, and those of other organizations from whom hourly services are purchased.

Printed material, not listed in Appendix A, will be billed for specific items furnished.

The Service Contractor shall have the right to adjust their fees as of the date (a) the Plan is amended to modify benefits, or (b) its cost of operation is increased solely by virtue of a change in charges to the Service Contractor by a governmental unit, but such adjustment shall be limited to the amount of the change. The Service Contractor also shall have the right to adjust their fees on the annual anniversary of this Agreement and annually thereafter.

Section 5. General Provisions

(a) The Service Contractor in performing its duties under this Agreement is acting only as agent of the Client, and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise herein provided.

(b) The Service Contractor shall use reasonable care and diligence in the exercise of its powers and the performance of its duties hereunder, but shall not be liable for any mistakes of judgment or other action taken in good faith, or for any loss unless resulting from its gross negligence.

(c) The Service Contractor agrees to indemnify the Client and hold the Client harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of the dishonest, fraudulent, criminal acts or acts of gross negligence of the Service Con-

tractor's employees, either acting alone or in collusion with others. The Service Contractor shall maintain Blanket Bond Coverage with a limit in reasonable proportion in the volume of claims administered.

(d) Except as provided in (c) above, the Client agrees to indemnify the Service Contractor and hold the Service Contractor harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of claims, demands, or lawsuits brought against the Service Contractor in administering the Plan or to recover benefits under the Plan, including compensatory, punitive, or other damages, and including but not limited to claims for premium taxes by any governmental unit or other assessments made against the Service Contractor by governmental units.

Supreme Court, U.S.
FILED
MAR 6 1992
OFFICE OF THE CLERK

No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK, GREENBERG, INDEPENDENT EXECUTOR
OF THE ESTATE OF
JOHN W. "JACK" McGANN
Petitioner,

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC
COMPANY, AND GENERAL AMERICAN LIFE
INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Fifth Circuit

BRIEF FOR RESPONDENTS H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY IN OPPOSITION

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QUESTIONS PRESENTED FOR REVIEW

1. Whether "any right" in ERISA § 510 means all rights, vested, non-vested, contingent or non-contingent at the time of contested employer actions?

2. Whether the uniform elimination of non-vested benefits, accomplished independently of employee discharge or harassment violates § 510 of ERISA?

3. Whether it is a defense to a plan participant's allegation of discrimination that a plan sponsor took action to save costs without taking actions that affected the employer-employee relationship?

4. Whether a self insured employer discriminates in violation of ERISA § 510 if the employer's medical plan contains a disease specific benefit cap?

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No. 91-1283

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1991

****

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

**ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

BRIEF FOR RESPONDENTS H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY IN OPPOSITION

Respondents submit this Brief to demonstrate that a Writ of Certiorari should be denied.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 946 F.2d 401. The opinion of the District Court is reported at 742 F.Supp. 392.

JURISDICTION

The judgment of the Court of Appeals was entered on November 4, 1991. The Petition for a Writ of Certiorari was filed on February 3, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. § 2101(c).

STATUTORY PROVISION INVOLVED

This case involves § 510 of the Employee Retirement Income Security Act of 1974 ("ERISA"), Publication Number 93-406, 88 Stat. 832 (29 U.S.C. § 1140) ("Section 510") which provides in pertinent part as follows:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, Section 1201 of this title, or the Welfare and Pension Plans Disclosure Act (29 U.S.C.A. § 301 *et seq.*), or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act.... The provisions of Section 1132 of this title shall be applicable in the enforcement of this section.

COUNTERSTATEMENT OF THE CASE

A. NATURE OF CASE

On August 2, 1989, Plaintiff, John McGann ("McGann") filed his First Amended Complaint against Defendants H & H Music Company ("H&H"), Brook Mays Music Company ("Brook Mays") and General American Life Insurance Company ("General American") for alleged violation of his rights under § 510 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA").[1] McGann alleged that Defendants discriminated against him because he exercised rights to which he was entitled under the provisions of H&H's Employee Benefit Plan. Specifically, McGann asserted that H&H, Brook Mays and General American interfered with the attainment of rights to which he would have become entitled under the plan by wrongfully changing the employee benefits coverage provided to McGann. (Resp. App. 13a-15a).[2]

All Defendants moved to dismiss the complaint under Rule 12, Federal Rules of Civil Procedure. These motions which the District Court did not consider separately were re-urged in subsequently filed Motions for Summary Judgment. For purposes of the Motions for Summary Judgment, all Defendants conceded the factual allegations contained in Plaintiff's First Amended Complaint. The District Court ruled that H&H had complied with ERISA; that it had the right to make changes in its group medical plan; and that it did not act in a discriminating manner in changing the terms of the plan.

---

[1]H&H Music Company and Brook Mays Music Company will be collectively referred to as "H&H" unless otherwise noted.

[2]Resp. App. cites refer to Respondents' Appendice.

The Final Judgment dismissing the case was entered on June 28, 1990. On appeal, a panel of the Fifth Circuit affirmed the judgment holding that McGann had not adduced evidence of any right to receive future medical benefits under the H&H Medical Benefits Plan, and therefore H&H did not unlawfully discriminate against McGann within the meaning of § 510 of ERISA.

B. FACTS

McGann had been an employee of H&H since 1982. During his employment, McGann had been covered by H&H's group medical care plan, which was administered by Brook Mays. Pursuant to the plan in effect from August 1, 1987 to July 31, 1988, all listed coverages were fully insured. The life and accidental death and dismem- berment insurance coverages were funded on a conventional premium basis. The medical coverage was funded by a minimum premium arrangement. General American received minimum premiums to administer and pay claims and to provide excess risk insurance for individual claims over $25,000. H&H was responsible for funding benefits covered by the plan up to the first $25,000. per Claimant. (Resp. App. 2a-7a).

In December, 1987, McGann was diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS"). He alleged that in March, 1988 he met with officials of H&H and discussed his illness. (Resp. App. 23a).

By letter dated July 28, 1988, Brook Mays announced that the medical care plan covering H&H's employees was terminated effective August 1, 1988 and that a new group medical/hospitalization plan would be put into place. (Resp. App. 26a-28a) The medical coverage changed from fully insured to self-insured. Pursuant to an Administrative Services Agreement, General American received

administrative services fees only to administer and pay claims. (Resp. App. 5a) In addition, General American received premiums for excess risk coverage to provide for individual claims over $25,000.00 and aggregate indemnification to limit the overall claim liability of the plan. Since the new plan was self-insured, no policy regarding medical benefits was issued to Brook Mays by General American. Rather the Summary Plan Description ("SPD") provided to employees contained the medical benefits offered by H&H. Benefits payable for AIDS related claims under the new plan were a lifetime maximum of $5,000.00. (Resp. App. 32a).

There were several additional major differences between the prior year's plan and the one that was instituted on August 1, 1988. Among these differences were the following:

1. The individual calendar year deductible was increased from $200.00 to $300.00. The family deductible was increased from $600.00 to $900.00;

2. The individual "stop loss" was increased from $4,000.00 in benefits to $10,000.00 in covered expenses;

3. All treatment for chemical dependency (drug abuse and alcoholism) was excluded from the plan;

4. A PPO (Preferred Provider Organization) network was added to the plan. Covered expenses in a PPO doctor's office were paid at one hundred percent (100%), subject to a Ten Dollar encounter fee instead of eighty

percent (80%), subject to the calendar year deductible. All other PPO doctor and hospital charges were paid at ninety percent (90%) instead of eighty percent (80%). Covered expenses for non-PPO providers remained unchanged.

5. Employee contributions were required to be increased by Two and 75/100 Dollars per payday for individual coverage and Seventeen and 50/100 Dollars per payday for family coverage.

The H&H Medical Benefits Plan was changed with the intent of preserving its financial integrity while at the same time allowing it to continue to provide health coverage for the employees of H&H. (Resp. App. 7a)

McGann received all of the benefits to which he was entitled under the H&H Medical Benefits Plan and did not complain of discriminatory treatment in the attainment of those benefits.

REASONS WHY THE WRIT SHOULD BE DENIED

COUNTERPOINT I

I. THE FIFTH CIRCUIT'S HOLDING THAT UNIFORM ELIMINATION OF NON-VESTED BENEFITS ACCOMPLISHED INDEPENDENTLY OF EMPLOYEE DISCHARGE OR HARASSMENT IS CONSISTENT WITH OTHER CIRCUIT COURTS' APPLICATION OF ERISA § 510.

A. *MCGANN HAD NO "RIGHTS" TO WHICH*

HE WOULD HAVE BECOME ENTITLED UNDER THE H&H PLAN.

McGann sought to create a right to permanent medical benefits by requiring that his medical benefits be afforded vested status. Without such a "right" to permanent medical benefits McGann did not have a claim of discrimination under § 510. *McGann* 946 F.2d 401, 405 (5th Cir. 1991). The Fifth Circuit did not, as is erroneously asserted by Petitioner, narrowly interpret § 510 to mean that it was only unlawful to interfere with an employee's right to recover "permanent" benefits under an ERISA plan. Rather the court found that McGann did not have a vested benefit, and thus he did not have a right to unchanged permanent medical benefits. Applying McGann's construction of § 510 would create a permanent obligation on the part of H&H where statutorily and contractually no obligation existed. McGann assumed he had a "right" to unchanged permanent medical benefits. This is wrong as a matter of law.

1. ***McGann did not have a vested benefit.***

The H&H welfare plan was not subject to the vesting requirements of 29 U.S.C. § 1140 and thus could be terminated at will. Termination of the plan necessarily terminated any rights McGann had to its benefits, since the plan would no longer be in existence to provide those benefits.

The H&H plan was a welfare benefit plan under § 3(1) of ERISA 29 U.S.C. § 1002(1). It provided life, accidental death and dismemberment and medical care benefits and was exempted from ERISA's vesting requirements. *Moore v. Metropolitan Life Insurance Company*, 856 F.2d 488, (2nd Cir. 1988). The *Moore* court stated the rationale for exempting welfare benefit plans from ERISA's vesting requirments:

> ERISA regulates pension plans far more extensively than welfare plans. For example, welfare plans are expressly exempted from the acts detailed minium participation, vesting and benefit accrual requirements and are not subject to ERISA's minimum funding requirements. As explained by committees of both the House and Senate, the term "accrued benefit refers to pension or retirement benefits and is not intended to apply to certain ancillary benefits, such as medical insurance or life insurance, which are sometimes provided for employees in conjunction with a pension plan, and are sometimes provided separately. To require the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income.

Moore, 856 F.2d at 491, citing H.R.Rep. No. 93-807, 93D Cong., 2d. Sess., reprinted in the 1974 U.S. Code Congressional and Administrative News 4639, 4670, 4726; S.Rep. No. 93-383, 93D Cong., 2d Sess., reprinted in 1974 U.S. Code Congressional and Administrative News 4639, 4890, 4935.

The Court in *Moore* also said that Congress intended the plan documents and the SPD to govern exclusively an employer's obligation under ERISA plans. *Id.* at 492. *See also, Andersen v. John Morrell & Co.* 789 F.2d 244 (3rd Cir. 1986); *Anderson v. Alpha Portland Industries, Inc.*, 647 F.Supp. 1109 (E.D. Mo. 1986), Affirmed, 836 F.2d 1512 (8th Cir. 1988).

The Eighth Circuit addressed the issue of termination

of welfare benefit plans in *Hamilton v. The Travelers Insurance Company*, 752 F.2d 1350 (8th Cir. 1985). In *Hamilton*, an employee brought a declaratory judgment action to establish that the defendant employer and health insurer were required to provide insurance benefits for expenses incurred in treating his son's eye injury after his son became nineteen (19) years of age and after the insurance policy was terminated. Causes of action were alleged for breach of contract and for violation of ERISA. The Court stated that:

> The Summary Plan Description Booklet provides that Altorfer, as the plan's administrator, may terminate the plan in whole or in part at any time, subject to the applicable provisions of the welfare insurance policies. Clearly, Altorfer was under no contractual obligation to refrain from terminating the plan. Finally, we agree with the District Court's conclusion that ERISA does not create liability on the part of the employer who changes the kind of health plan provided to employees where no contract prohibits or prevents such change.

Id. at 351. The Court then concluded that the employer and insurance company were entitled to judgment as a matter of law since ERISA did not prohibit them from terminating this medical benefits plan. *See also, Hamilton v. The Travelers Insurance Company*, 587 F.Supp. 521 (D. Missouri, 1984) (Citing *Gutting v. Falstaff Brewing Corp.*, 541 F.Supp. 345 (E.D. Missouri 1982), *See also* 29 U.S.C. § 1341-1348 (1982).

Similarly, in *Tackitt v. Prudential Insurance Company of America*, 758 F.2d 1572 (11th Cir. 1985), the court held

that the defendants could reduce plan benefits based upon the unambiguous language of the plan documents. *See also Alday v. Container Corp. of America*, 906 F.2d 660 (11th Cir. 1990) *cert. denied* 111 S.Ct. 675 (1991), *Philips v. Amoco Oil Company*, 799 F.2d 1464 (5th Cir. 1986) *cert. denied* 481, U.S. 1016 (1987). *No other Circuit Court has held that medical benefits vest.*

The Fifth Circuit's ruling is consistent with the legislative history of ERISA, as well as decisions rendered in other circuits regarding vesting of medical benefits.

2. *Only the Plan was affected, not McGann's employment.*

Many courts have expressly held that § 510 requires that the individual's employment relationship, not merely the plan, be affected by the alleged discrimination. *Deeming v. American Standard, Inc.*, 905 F.2d 1124, (7th Cir. 1990).

The type of discrimination that Congress intended to prohibit under § 510 is a claim for termination of employment "motivated by an employer's desire to prevent a pension from vesting." *Ingersoll-Rand Co. v. McLendon*, 498 U.S. _____ 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). ERISA's legislative history confirms that Congress enacted § 510 in order to prevent unscrupulous employers from discharging or otherwise interfering with the employment status of employees whose pension rights were about to vest:

> These provisions were added by the committee in the face of evidence that in some plans a workers' pension rights or the expectations of those rights were interfered with by the use of economic sanctions or violent reprisals.

S.Rep. No. 93-127, 93d Cong., 2d Sess., *reprinted at* (1974) U.S. Code Cong. & Admin. News, pp. 4838, 4872, *quoted in West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

McGann cites numerous cases in support of his proposition that H&H discriminated against him, and in support of the charge that the Fifth Circuit is in conflict with other circuits. However, in each of these cases the employment relationship and not the plan was affected by employer action. Those cases correctly hold that termination of employment is a violation of § 510, if the purpose of the termination was to interfere with an employee's continued coverage under an insurance plan or for the purpose of interfering with the attainment of a right under either a pension or a welfare benefit plan. *See, Fitzgerald v. Codex Corp.*, 882 F.2d 586 (1st Cir. 1989); *Kross v. Western Electric Co.*, 701 F.2d 1238 (7th Cir. 1983); *Folz v. Marriott Corp.*, 594 F.Supp. 1007 (W.D. Mo. 1984); *Vogel v. Independence Federal Savings Bank*, 728 F.Supp. 1210 (D.Md. 1990). Yet, McGann's employment was never terminated. Since only the plan was affected and not McGann's employment relationship, the Fifth Circuit correctly restricted the application of ERISA § 510.

B. THE FIFTH CIRCUIT'S INTERPRETATION OF "DISCRIMINATION" IS CONSISTENT WITH CONGRESS' INTENT THAT EMPLOYERS REMAIN FREE TO CREATE, MODIFY AND TERMINATE THE TERMS AND CONDITIONS OF EMPLOYEE BENEFITS PLANS WITHOUT GOVERNMENTAL INTERFERENCE.

McGann cites no case to support the proposition that Congress explicitly limited an employer's discretion to alter the terms of welfare benefit plans by enacting ERISA § 510.

> McGann effectively contends that § 510 was intended to prohibit any discrimination in the alteration of an employee benefits plan that results in an identifiable employee or group of employees being treated differently from other employees.

McGann, 946 F.2d at 406. This position is wrong as a matter of law and it is not consistent with the holdings from other circuits.

First, under ERISA, discrimination can only be proven by showing: (1) prohibited employer conduct, (2) taken for the purpose of interfering, (3) with the attainment of any right to which the employee may become entitled. *Gavalik v. Continental Can Co.*, 812 F.2d 834 (3rd Cir. 1987). McGann presented no evidence to suggest that the action taken by H&H was prohibited. Employer conduct, so long as it is not prohibited, may lawfully interfere with an employee's rights. Many courts have thus recognized an employer's lawful reduction of employee benefits. *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454 (6th Cir. 1984); *Musto v. American General Corp.*, 861 F.2d 897 (6th Cir. 1988); *Moore v. Metropolitan Life Insurance Company, supra.* The reduction of benefits does not constitute discrimination.

The First Circuit rejected a contention similar to McGann's in *Aaronson v. Servus Rubber Div. of Chromalloy*, 730 F.2d 12 (1st Cir.) *cert. denied* 469 U.S. 1017, (1984). The Court in *Aaronson* stated in part:

> § 510 relates to discriminatory conduct directed against individuals, not to actions involving the plan in general. The problem is with the word 'discriminate.' An overly lit-

> eral interpretation of this Section would make illegal any partial termination, since such terminations obviously interfere with the attainment of benefits by the terminated group, and indeed, are expressly intended so to interfere.

See also Owens v. Storehouse, Inc., 773 F.Supp. 416, 418 (N.D. Ga. 1991) (relying on *Deeming* in rejecting a claim that employer violated § 510 by reducing AIDS benefits from One Million to $25,000.00 under employee health plan on the ground that § 510 was designed to protect the employment relationship, not the integrity of specific plans.)

ERISA only concerns the elements of a plan and its administration after it has been established. It does not affect the creation of a program. ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, (1983). ERISA does not require an employer to establish a hospitalization plan, nor continue it indefinitely. *Viggiano v. Shenango China Division of Anchor Hocking*, 750 F.2d 276 (3rd Cir. 1984). Additionally, once an employer makes a determination to provide a welfare benefit plan:

> Neither Congress nor the Courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide. In particular, Courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the market place and, when appropriate, by Federal Legislation.

Moore v. Reynolds Metals Co. Retirement Program, 740 F.2d at 456.

Moreover, a company in its role as employer can change the design of its welfare benefit plan for a purpose other than that of benefiting the plan's participants and their beneficiaries.[3] *Musto v. American General Corp.*, 861 F.2d at 911. The H&H plan terminated on July 31, 1988. Contractually, any benefits to which McGann was entitled terminated on that date as well. Under the H&H plan, the only rights McGann had were those set out in the SPD; he could not obtain rights greater than those which were contractually owed through the plan documents. Finally, H&H's new self-insured welfare benefit plan could place a sublimit on its lifetime benefits payable on any particular disease. The Fifth Circuit's reading of the statute clearly comports with case law, public policy and Congressional intent on these issues.

COUNTERPOINT II

II. THE FIFTH CIRCUIT DID NOT CREATE A NEW BURDEN OF PROOF FOR PLAINTIFFS IN § 510 CASES.

The Fifth Circuit did not elevate cost savings to the status of an absolute defense. The court recognized that McGann offered no evidence to substantiate his claim of discrimination beyond the defendants' admitted sole purpose of saving money. Defendants' admission was not sufficient

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[3]The Court in *Musto v. American General Corp.*, cited the testimony of Mr. Donald S. Grubbs, Jr., a consulting actuary and attorney who had been retained to advise the Senate Subcommittee that developed ERISA. According to the Court, Grubbs testified that Congress clearly did not attempt to preclude the right of employers to reduce benefits under welfare plans.

evidence of their discriminatory intent absent evidence of additional prohibited conduct affecting the employer-employee relationship.

McGann did not have a right to permanent unchanged medical benefits either statutorily or contractually. The lawful termination of H&H's plan and the subsequent cap on benefits was not sufficient evidence of the Defendants' discriminatory intent. The court noted,

> McGann appears to contend that the reduction in AIDS benefits alone supports an inference to retaliate against him or to interfere with his future exercise of rights under the plan... under McGann's theory, any reduction in employee benefits would be impermissibly discriminatory if motivated by desire to avoid the anticipated cost of continuing to provide coverage for a particular beneficiary.

McGann, 946 F.2d at 405. Cost savings can support a finding of unlawful motivation, but there must be evidence of additional prohibited employer conduct to support a § 510 claim, *e.g.*, termination of employment. This additional prohibited conduct is absent in this case.

McGann failed in meeting his burden of adducing some evidence that the Defendants intended to discriminate against McGann and McGann only for filing AIDS related claims. The Fifth Circuit did not create a new burden of proof but rather held McGann to the standard required by numerous decisions. *Kimbro v. Atlantic Richfield Co.*, 889 F.2d 869, 881 (9th Cir. 1989) (employee must prove employer's specific intent to retaliate for employee's exercise of rights under plan) *cert. denied*, _____ U.S. _____, 111 S.Ct. 53, 112 L.Ed. 2d 28 (1990); *Clark v. Resisto Flex Co.*,

a Division of UniDynamics Corp., 854 F.2d 762, 770 (5th Cir. 1988), *Dister v. Continental Group, Inc.*, 859 F.2d 1108 (2nd Cir. 1988); *Gavalik v. Continental Can Co.*, *supra*.

COUNTERPOINT III

III. THERE ARE NO PUBLIC POLICY REASONS FOR GRANTING THE PETITION

The Fifth Circuit's decision rejecting this § 510 claim is consistent with the principle that Congress did not intend that ERISA circumscribe employers' control over the content of benefits plans they offer to their employees.

> If a Federal Court could prevent an employer from reducing an employee's coverage limits for AIDS treatments, once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alteration or termination of ERISA plans would be sorely tested.

McGann, 946 F.2d at 407-408.

Congress knew that every time an employer reduced the medical benefits offered through that employer's welfare benefit plan, the employer intended to deprive its employees of the affected benefits. To accept McGann's rationale is to accept the proposition that medical benefits, once in place, can never be reduced without violating § 510 of ERISA. Congress never intended this application, and McGann was never entitled to health benefits whose terms would never change.

Medical plans, and the basis upon which they are

offered and paid for, are different from pension plans. Congress recognized this fact in the statutory scheme defining the difference between pension plans and welfare plans containing medical benefits.

> With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. Automatic vesting was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the cost of treatment independent of inflation. These unstable variables prevent accurate prediction of future needs and costs. While these Plaintiffs would be helped by a decision in their favor, such a ruling would not only fly in the face of ERISA's plain language but would also decrease protection for future employees and retirees.

Moore v. Metropolitan Life Insurance Company, 856 F.2d at 492. An employer should be able to consider increased costs of future treatments and future needs in tailoring its medical plans. H&H was statutorily entitled to consider the future anticipated cost to its welfare benefit plan of AIDS treatment. Similarly, H&H was entitled to consider the cost to its welfare benefit plan of any other coverage, such as for alcohol and drug abuse treatment.

The court in *Musto v. American General Corp.*, stated

the rationale for allowing employers the right to amend their welfare benefit plans when it stated the following:

> National Life had no fiduciary duty to establish any medical insurance plan, much less one that could never be amended without the approval of those to whom it applied. It is hard to see how the company's express reservation of a right to amend the plan can be said to constitute 'over reaching' when a prudent employer, mindful of the possibility that medical costs might skyrocket, could well have decided, if given the slightest reason to suppose that future amendments to the medical insurance coverage could be invalidated under ERISA, not to provide such coverage at all, or to impose the most stringent limits on any coverage provided.

Musto, 861 F.2d at 912.

Public policy requires that employers be given wide latitude in designing their welfare benefits plans as the *Moore* and *Musto* Courts noted. McGann's public policy argument flies in the face of common sense. Employers provide jobs; they are not yet required to provide health insurance. To the extent employers provide medical benefits, their plans must be administered fairly. However, employers should remain free to offer whatever benefits they choose, or as the *Musto* Court explained, employers may offer no coverage at all. Given the choice between a system of no coverage or a system of employer chosen benefit packages, public policy mandates the latter choice. McGann's public policy argument would eliminate that choice and, in all probability, medical insurance coverage for a large number of Americans. The Fifth Circuit's decision recognized this reality and the consequences of a different decision.

would eliminate that choice and, in all probability, medical insurance coverage for a large number of Americans. The Fifth Circuit's decision recognized this reality and the consequences of a different decision.

CONCLUSION

The Fifth Circuit's decision in this case and its reading of § 510 of ERISA is consistent with Congressional intent, the public policy behind that intent and other circuits' decisions and therefore respondents respectfully submit that this court deny petitioner's request for writ of certiorari.

Dated: Houston, Texas
February 17, 1992

Respectfully submitted,

HARBERG, HUVARD & BISK

By: _____

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN MCGANN,
PLAINTIFF

vs.
H&H MUSIC CO., BROOK MAYS MUSIC CO., AND GENERAL AMERICAN LIFE INSURANCE COMPANY
DEFENDANTS

CIVIL ACTION
NO. 89-1995

AFFIDAVIT

BEFORE ME, the undersigned authority, on this day personally appeared William C. Everitt, Sr., who being by me duly sworn upon his oath, deposed and stated the following:

"My name is William C. Everitt, Sr., and I am over the age of eighteen (18) years and am competent to make this Affidavit. I am Chairman of the Board of H&H Music Company and Brook Mays Music Company, two (2) of the Defendants in the above styled and numbered cause. Additionally, I am familiar with all of the allegations contained in the Plaintiff's First Amended Complaint, and I have personal knowledge of the facts stated herein.

At all times material to the allegations contained in the Plaintiff's First Amended Complaint, the employees of H&H Music Company were entitled to participate in Brook Mays Music Company's welfare plan providing life, accidental death, and dismemberment and medical care benefits. The plan's sponsor and Administrator was Brook Mays Music Company. Throughout the years, the benefits offered to the employees of both Brook Mays Music

Company and H&H Music Company have changed substantially.

Effective September 1, 1983, Brook Mays Music Company was issued Policy Number MCP-5353 (reissued) by General American Life Insurance Company. That policy was amended from time to time as is evident from Exhibit "A" to the Appendix attached hereto. After the initial effective date of the policy, September 1, 1983, each policy year began on August 1 of each successive year. In December, 1987, when Plaintiff Jack McGann was diagnosed as having AIDS, this was the health policy in effect. All of the coverages under this policy were fully insured. The life and accidental death and dismemberment insurance coverages were funded by a conventional premium basis. The medical coverage was funded by a minimum premium arrangement. General American received minimum premiums to administer and pay medical claims and to provide excess risk insurance for individual claims over Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate insurance to limit the overall claim liability of the plan.

There were a number of ways to fund the insurance coverages obtained from time to time by Brook Mays Music Company. Funding methods do not necessarily affect whether or not a welfare plan is fully insured or self insured. Under a traditional, conventional funding method, Brook Mays Music Company would have been charged a premium based upon the insurance carrier bearing one hundred percent (100%) of the risk of all claims. General American Insurance Company would calculate Brook Mays Music Company's premium based upon actual experience and General American's underwriting guidelines. In the event that claims were not overly excessive in any plan year, the premiums paid might be in excess of the amount actually required to fully compensate General American. In this instance, the surplus premium paid would be returned to

Brook Mays Music Company in the form of a dividend.

Brook Mays Music Company went to a minimum premium funding method for the plan year beginning August 1, 1984. This method of funding had no impact on the Company's welfare plan which remained fully insured, but rather only affected the amount of premium payable on an up-front basis by Brook Mays Music Company to General American Insurance Company. For the plan year beginning August 1, 1987, Brook Mays Music Company was responsible for paying individual claims up to Twenty-Five Thousand and no/100 Dollars ($25,000.00). General American Insurance Company provided excess risk insurance, which covered claims above Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate insurance to limit the total number of dollars that would need to be paid by Brook Mays Music Company under this plan. For the plan year beginning August 1, 1987, through July 31, 1988, the minimum premium per employee per month for medical coverage only was Thirty-Six and 49/100 Dollars ($36.49).

During the plan years prior to August 1, 1988, the losses for the plan had mounted steadily. In the immediate prior year, for every dollar that was received in premium, almost One and 50/100 Dollars ($1.50) was spent in benefit payment payments. Brook Mays Music Company was faced with either dropping the plan completely or redesigning the benefits in order to get costs back under control in order that all employees could still receive benefits under this welfare plan. Therefore, the old welfare plan was terminated, and beginning August 1, 1988, a new plan was instituted. Under the new plan, the life, accidental death and dismemberment coverages remained fully insured and continued to be funded by conventional premium basis. The medical coverage changed from fully insured to self-insured. This meant that Brook Mays Music Company would pay directly all claims that were covered under the plan. General American

Insurance Company received administrative services fees to administer and pay claims under an Administrative Services Agreement. Brook Mays Music Company additionally purchased indemnification coverage and consequently, General American received premiums to provide excess risk coverage providing specific indemnification for individual claims in excess of Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate indemnification to limit the overall claim liability of the plan.

There were several major differences between the prior year's plan and the one that was instituted on August 1, 1988. Among these differences were the following:

1. The individual calendar year deductible was increased from Two Hundred and no/100 Dollars ($200.00) to Three Hundred and no/100 Dollars ($300.00). The family deductible was increased from Six Hundred and no/100 Dollars ($600.00) to Nine Hundred and no/100 Dollars ($900.00);
2. The individual "stop loss" was increased from Four Thousand and no/100 Dollars ($4,000.00) in benefits to Ten Thousand and no/100 Dollars ($10,000.00) in covered expenses;
3. Treatment for AIDS (Acquired Immunity Deficiency Syndrome) and ARC (AIDS Related Complex) were limited to individual lifetime maximum of five Thousand and no/100 Dollars ($5,000.00);
4. All treatment for chemical dependency (drug abuse and alcoholism) was excluded from the plan;
5. A PPO (Preferred Provided

> Organization) network was added to the plan. Covered expenses in a PPO doctor's office were aid at one hundred percent (100%), subject to a Ten and no/100 Dollar ($10.00) encounter fee instead of eighty percent (80%), subject to the calendar year deductible. All other PPO doctor and hospital charges were paid at ninety percent (90%) instead of eighty percent (80%). Covered expenses for non-PPO providers remained unchanged.

The premium cost for medical coverage only per employee per month under this plan was Forty-Two and 58/100 Dollars ($42.58).

The number of employees covered by the Brook Mays welfare plan as of August 1, 1987, was one hundred fifty-two (152). The number of employees covered as of August 1, 1988, was one hundred forty-three (143). For the plan year beginning August 1, 1987, the welfare plan cost an average of One Hundred Three and 93/100 Dollars ($103.93) per employee per month. The plan cost for the year beginning August 1, 1988, was Ninety Two and 32/100 Dollars ($92.32) per employee per month. Had there been no change from the plan provided in the 1987 plan year to the 1988 plan year, the minimum medical premium per employee per month would have risen to Forty-Eight and 91/100 Dollars ($48.91) per month with a projected claims' liability of One Hundred Seventy Four and 07/100 Dollars ($174.07) per employee per month. Even changing plans did not allow employee contributions to remain status quo. Employee contributions were required to be increased by Two and 75/100 Dollars ($2.75) per payday for individual coverage and Seventeen and 50/100 Dollars ($17.50) per payday for family coverage.

The decisions which were made regarding these plans were difficult ones, but were done with the intent of preserving the financial integrity of the welfare plan while at

the same time allowing it to continue to provide health coverage for the employees of Brook Mays and H&H Music Companies."

Further affiant sayeth not.

/s/_____
WILLIAM C. EVERITT,SR.

SWORN TO and subscribed before me this the 8 day of January, 1990.

/s/_____
NOTARY PUBLIC
Carl B. Bolin
Typed Name of Notary

Notarial Seal

EXHIBIT "A"

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
PLAINTIFF

vs. CIVIL ACTION
H & H MUSIC COMPANY NO. H-89-1995
BROOK MAYS MUSIC
COMPANY, AND GENERAL JURY DEMAND
AMERICAN LIFE
INSURANCE COMPANY,
DEFENDANTS

PLAINTIFF'S FIRST AMENDED COMPLAINT

JOHN MCGANN, Plaintiff, complains of H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY, Defendants, as follows:

INTRODUCTION

1. Plaintiff brings this action for violation of his rights under §1140 of the Employee Retirement Income Security Act of 1974 (hereafter "ERISA"), 29 U.S.C. § 1001 et seq. Plaintiff alleges that Defendants have discriminated against him for exercising rights to which he is entitled under the provisions of an employee benefit plan, and for the purpose of interfering with the attainment of rights to which Plaintiff may become entitled under such plan, by wrongfully changing the employee benefits coverage provided to Plaintiff through his employment with Defendant H & H MUSIC COMPANY and provided through BROOK MAYS MUSIC COMPANY. Because of the continuing and irreparable nature of the resulting injury, Plaintiff seeks expedited preliminary injunctive relief from this Court restoring to him all prior benefits. Plaintiff also seeks, pursuant to §1140 of

ERISA, reasonable attorneys' fees and costs, all benefits due to him under the terms of his prior benefit plan, and permanent injunctive relief restraining Defendants from further discriminating against Plaintiff.

2. Plaintiff also invokes this Court's power of pendant jurisdiction and brings a claim pursuant to § 501(1) of the Texas Commission on Human Rights Act, V.A.T.S. art. 5221k (1987). Plaintiff alleges that Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY discriminated against him with regard to his employment-related benefits on account of his handicap, Acquired Immune Deficiency Syndrome (hereafter A.I.D.S"). Pursuant to the Texas Commission on Human Rights Act, Plaintiff seeks injunctive relief, cost and attorneys' fees, and compensatory damages.

3. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21, § 4(7)(b), prohibiting "unfair discrimination" in the benefits or terms and conditions in any contract of health insurance or payment of benefits thereunder. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY discriminated against him by refusing to insure or refusing to continue to insure Plaintiff due to his handicap. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, in addition, two times the amount of actual damages.

4. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21-3, entitled "Discrimination Against Handicapped Prohibited," which prohibits an insurer from discriminating against a handicapped insured by

refusing to insure or refusing to continue to insure a handicapped individual. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY unfairly discriminated against him by initiating a cessation of coverage. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16. Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, in addition, two times the amount of actual damage.

5. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 et seq., the Texas Deceptive Trade Practices-Consumer Protection Act, which prohibits "false, misleading, or deceptive acts or practices in the conduct of any trade or commerce." Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, in providing its service as group insurer, committed false and deceptive acts by inducing certain acts or events so as to cause itself to change from insurer of the medical/hospitalization policy of Defendants H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY to merely becoming the administrator of such policy. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of facts finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed unconscionable acts, or acts in violation of V.A.T.S. Insurance Code art. 21.21, the Court shall award not more than three times the amount of actual damages in excess of $1,000.00.

6. Plaintiff also invokes the court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 et seq., the Texas Deceptive Trade Practices-Consumer protection Act, which prohibits "false,

misleading, or deceptive acts or practices in the conduct of trade or commerce." Plaintiff alleges that Defendant employer, H & H MUSIC COMPANY, as fiduciary for the medical/hospitalization policy for employee JOHN McGANN, your Plaintiff, committed fraudulent acts by its intent to conceal from the Plaintiff, through a concerted effort with the other Defendants, that the medical/hospitalization group policy on which Plaintiff would rely to obtain his medically necessary treatments, would be modified to eliminate medical/hospitalization benefits. Plaintiff relied upon Defendant H & H MUSIC COMPANY to act as a proper fiduciary, and Plaintiff's reliance upon Defendant H & H MUSIC COMPANY has caused Plaintiff immense injury. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court cost, and attorneys' fees. If the trier of fact finds that Defendant H & H MUSIC COMPANY knowingly committed unconscionable acts, or acts in violation of V.A.T.S. BUS. & COM. CODE § 17.50, the Court shall award not more than three (3) times the amount of actual damages in excess of $1,000.00.

7. Plaintiff also brings causes of action for breach of contract, and related state law claims against Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, arising out of the breach of fiduciary duties by Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY.

JURISDICTION

8. This Court has jurisdiction of this action under § 1132(e) of ERISA, 29 U.S.C. § 1001 *et seq.*, and under its power of pendant jurisdiction to hear Plaintiff's state law claims. The state law claims and the federal law claims derive from a common nucleus of operative fact.

PARTIES

9. Plaintiff JOHN McGANN is a resident of Houston, Harris County, Texas, and a citizen of the United

States. He has been employed by Defendant H & H MUSIC COMPANY since 1982.

10. Defendant H & H MUSIC COMPANY is a Texas Corporation, doing business as a music store in Houston, Harris County, Texas. Its registered agent is Clyde W. Reynolds, who may be served with process at 1211 Caroline, Houston, Harris County, Texas 77002.

11. Defendant BROOK MAYS MUSIC COMPANY is a Texas corporation, doing business in Houston, Harris County, Texas. Its registered agent is William C. Everitt, who may be served with process at 644 West Mockingbird, Dallas, Dallas County, Texas 75247.

12. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY is a Missouri corporation, doing business in Texas. Its registered agent for service is Robert E. Jackson, who may be served with process at 1200 Summit Avenue, Suite 500, Fort Worth, Tarrant County, Texas 76102.

FACTS

13. At all relevant times, Defendant H & H MUSIC COMPANY was an employer engaged in an industry or activity affecting commerce within the meaning of 29 U.S.C. § 1002(5),(11), and (12) and § 2.01(5) of V.A.T.S. art. 5221k (1987).

14. At all material times, Plaintiff JOHN McGANN was an employee of Defendant H & H MUSIC COMPANY within the meaning of 29 U.S.C. § 1002(6) and § 2.01(4) of V.A.T.S. art. 5221k.

15. Defendant H & H MUSIC COMPANY'S employee benefits plan, including but not limited to its group medical/hospitalization benefits plan, is an employee benefit plan within the meaning of 29 U.S.C. § 1002(3) and 29 U.S.C. § 1140, and whose Plan Administrator is Defendant BROOK MAYS MUSIC COMPANY.

16. Plaintiff JOHN McGANN was and is a

participant in Defendant BROOK MAYS MUSIC COMPANY's employee benefits plan within the meaning of 29 U.S.C. § 1002(7) and 29 U.S.C. § 1140.

17. Plaintiff JOHN McGANN has been employed by Defendant H & H MUSIC COMPANY since 1982, and thereafter covered by Defendant BROOK MAYS MUSIC COMPANY's Group Medical Care Plan.

18. In December, 1987, Plaintiff JOHN McGANN was diagnosed as having A.I.D.S. This fact was well known by all defendants.

19. On August 3, 1988, Defendant BROOK MAYS MUSIC COMPANY announced that its Group Medical Care Plan covering Defendant H & H MUSIC COMPANY's employees, and wherein Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY had been insurer, was canceled effective August 1, 1988, and that the substituted group medical/hospit-alization policy would be self-insured, with Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY as administrator only. Benefits payable for A.I.D.S-related claims were modified from a lifetime maximum covered expense of $1,000,000.00 to only $5,000.00, and therefore potentially excluded $955,000.00 in insured expenses available to Plaintiff JOHN McGANN.

20. On October 12, 1988, Plaintiff JOHN McGANN filed a complaint with the Texas Commission on Human Rights, alleging that he was discriminated against by Defendant H & H MUSIC COMPANY on account of his handicap, A.I.D.S (TCHR Complaint No. 3890030). On or about April 10, 1989, he receive his "Notice of Right to File A Civil Action" from the Texas Commission on Human Rights.

21. Plaintiff believes that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY acted in conspiracy with Defendant H & H MUSIC COMPANY and Defendant BROOK MAYS MUSIC COMPANY to violate Plaintiff's rights under ERISA and to discriminate against

Plaintiff on account of his handicap, A.I.D.S. Prior to August 1, 1988, Plaintiff was fully insured for his handicapping condition of A.I.D.S for the maximum expense of $1,000,000.00. On August 1, 1988, the Defendants acted in concert in conspiring to discriminate against Plaintiff JOHN McGANN. Defendants schemed so that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's obligations to Plaintiff JOHN McGANN would cease by termination of the General American policy and by imposition of an H & H Music Company/Brook Mays Music Company self-insured plan that limited the obligations of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to no more than $5,000.00 for claims related to Plaintiff's handicapped condition, but, again, whereby Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY remained administrator of the policy and no longer liable.

22. Defendants' wrongful actions towards Plaintiff have caused Plaintiff considerable mental suffering. Medical studies have consistently shown that increased anxiety levels, like that induced in Plaintiff by Defendants' actions, increase the likelihood or repeated infections and further worsen existing infections and medical problems of A.I.D.S patients.

FIRST CAUSE OF ACTION

Interference with Protected Rights Under ERISA

23. Defendants, by conspiring together to change Plaintiff's insurance coverage, acted for the purpose of interfering with Plaintiff's attainment of rights to which he was entitled or may have become entitled under the employee benefit plan of Defendant H & H MUSIC COMPANY or under ERISA, 29 U.S.C. § 1001 *et seq.* Defendants' actions thus constitute a violation of § 1140 of ERISA. As a result of Defendants' conspiratorial actions, Plaintiff has lost benefits of employment, suffered mental anguish, and been forced to employ attorneys in order to vindicate his rights and to obtain other appropriate equitable relief. In addition,

Plaintiff has been forced to accept an inferior medical/hospitalization insurance plan, which in essence is of little or no value, as it conveniently exempts those treatments that are necessary for maintenance of Plaintiff JOHN McGANN'S health.

SECOND CAUSE OF ACTION
Texas Commission on Human Rights Act

24. Defendant H & H MUSIC COMPANY discriminated against Plaintiff JOHN McGANN by changing his insurance coverage on account of his handicap, A.I.D.S., in violation of § 5.01(1) of the Texas Commission of Human Rights Act, V.A.T.S. art. 5221k (1987). As a result, Plaintiff has lost benefits of employment, suffered mental anguish, and has had to employ attorneys in order to vindicate his rights.

THIRD CAUSE OF ACTION
Violation of V.A.T.S. Insurance Code,
Art. 21.21

25. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, by conspiring together with Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to change Plaintiff's insurance coverage, sought to unfairly discriminate in the benefits or terms and conditions of their health insurance plan effective prior to August 1, 1988. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's actions constitute a violation of V.A.T.S. Insurance Code, art. 21.21, *et seq.* As a result of their acts, Plaintiff has lost benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition.

FOURTH CAUSE OF ACTION
Violation of State Insurance Laws
Protecting Handicapped

26. Defendants, by conspiring together to change

Plaintiff's insurance coverage, sought unfairly to discriminate against Plaintiff, a handicapped person, by refusing to insure, or refusing to continue to insure, Plaintiff. As a result of these acts, Plaintiff has been damaged by the loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition pursuant to V.A.T.S. Insurance Code, art. 21.21-3.

FIFTH CAUSE OF ACTION
Deceptive Trade Practices by
Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY

27. Defendants, by conspiring together to change Plaintiff's insurance coverage, caused Plaintiff to be damaged by Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's false and deceptive acts by causing Plaintiff's existing medical policy to prematurely terminate. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's acts were knowingly committed in violation of V.A.T.S. BUS. & COM. CODE § 17.41 *et seq.*; and, accordingly, Plaintiff has been damaged by the untimely loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his medical needs related to his handicapped condition.

SIXTH CAUSE OF ACTION
Deceptive Trade Practices by
Defendants H & H MUSIC COMPANY
and BROOK MAYS MUSIC COMPANY

28. By conspiring together to change Plaintiff's insurance coverage, Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY caused Plaintiff to be damaged by their false and deceptive acts, by their efforts to conceal information that they were purposely modifying their insurance policies to eliminate medical/hospitalization benefits that they knew were necessary to sustain Plaintiff. As a further direct and proximate result of this breach of

duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of the false and deceptive acts of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

SEVENTH CAUSE OF ACTION
Breach of Duty Created by Agency

29. Defendant H & H MUSIC COMPANY acted as Plaintiff's agent for the purpose of doing generally what was needed to obtain and preserve insurance coverage for employees of H & H MUSIC COMPANY and owed to Plaintiff the duty owed by an agent to a principal. Defendant H & H MUSIC COMPANY breached this duty to Plaintiff by failing to notify Plaintiff, as obligated by such agency relationship, of the impending cessation of his needed medical/hospitalization benefits related to his known handicap. As a result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

STATEMENT OF IRREPARABLE HARM

30. Plaintiff requests an expedited hearing on his request for preliminary injunctive relief, as Plaintiff will suffer irreparable injury unless this Court immediately orders Defendants to restore to Plaintiff his prior health insurance coverage, and restrains Defendants from further unlawful discrimination against Plaintiff. Defendants' unlawful actions are depriving Plaintiff of appropriate and necessary health insurance, and causing him to fear imminent financial and emotional helplessness. Such threatened injuries clearly outweigh any damage the requested injunction might cause to

Defendants' interests, and the interests of the public coincide with those of Plaintiff. Plaintiff has no adequate remedy at law due to the daily worsening of Plaintiff's financial and emotional states.

31. Plaintiff hereby demands a JURY on all issues triable by jury.

Wherefore, Plaintiff requests the following relief:

1. that, following an expedited hearing a preliminary injunction be issued to restore to Plaintiff his former insurance benefits; and that Plaintiff be granted a permanent injunction upon trial of this case;
2. that Plaintiff recover his compensatory damages, including the value of his lost insurance coverage, valued at NINE HUNDRED FIFTY-FIVE THOUSAND AND NO/100 ($955,000.00) DOLLARS and, additionally, such other actual damages as shall be proved at trial resulting from Defendants' unlawful conduct;
3. that Plaintiff, in addition to recovering actual damages, recover additional damages of TWO MILLION NINE HUNDRED EIGHTY-FIVE THOUSAND AND NO/100 ($2,985,000.00) DOLLARS, as pleaded, should the trier of fact find the requisite knowledge in the commission of Defendants' conspiratorial scheme;
4. that Plaintiff recover damages for his mental anguish resulting from Defendants' tortious and discriminatory conduct;
5. that Plaintiff recover punitive damages due to Defendants' malice and bad faith and as justified by the evidence at trial in a sum in excess of ONE MILLION AND NO/100 ($1,000,000.00) DOLLARS;

6. that Plaintiff be awarded prejudgment and post judgment interest at the maximum legal rate;
7. that Plaintiff recover reasonable attorneys' fees; and
8. that Plaintiff be awarded his costs of court and any other relief to which he proves himself entitled.

Respectfully submitted,

/s/ Helen Brattin
Helen Brattin
Southern District ID No. 5072
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

/s/Donald L. Skipwith
Donald L. Skipwith
Southern District ID No. 1841
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

ATTORNEYS FOR PLAINTIFF

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
Plaintiff
vs.
H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Civil Action
No. H-89-1995

VERIFICATION

STATE OF TEXAS §
§
COUNTY OF HARRIS §

BEFORE ME, the undersigned authority, on this day personally appeared JOHN McGANN, who, being by me duly sworn, made the following statements:

"My name is JOHN McGANN, and I am the Plaintiff in this cause. I am aware of the factual allegations of Plaintiff's First Amended Complaint, and all such factual allegations therein are true and correct."

s/s John McGann
John McGann

SWORN TO AND SUBSCRIBED BEFORE ME this 25 day of July, 1989.

/s/ Audrey L. Seawright
Notary Public in and for
the State of Texas
/s/ Audrey L. Seawright
Printed Name of Notary Public

My Commission expires:7/20/92

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
Plaintiff

vs.

Civil Action
No. H-89-1995

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY
Defendants

AFFIDAVIT OF JOHN McGANN

STATE OF TEXAS §
§
COUNTY OF HARRIS §

BEFORE ME, the undersigned authority, on this day personally appeared JOHN McGANN, who, being by me duly sworn, stated as follows:

"My name is JOHN McGANN. I am over the age of twenty-one (21) years and fully competent to make this affidavit. I am the plaintiff in the above-captioned lawsuit and am employed by Defendant H & H Music Company (hereafter 'H & H').

"In December 1987, I was hospitalized for pneumonia and diagnosed as having Acquired Immune Deficiency Syndrome ('AIDS').

"Although I was devastated by my diagnosis, I had every intention of fighting the virus by availing myself of the best of medical care. As an employee of H & H Music Company for six (6) years, I believed that I would be able to access payment of my needed medical care through my group medical/hospitalization insurance with H & H Music

Company. One of the first things I did after my diagnoses was to educate myself concerning the provisions and benefits of my insurance coverage. I had heard that there were insurance companies that discriminated against people with AIDS, but I never thought that this would be my case.

"My first claims for insurance benefits for this illness were submitted to the insurance carrier, Defendant General American Life Insurance Company (hereafter 'General American') in either Dcember 1987 or January 1988.

"Shortly after I returned to work at H & H, in early 1988, I told Charles Vick, the manager of my department at H & H, that I had AIDS. In March 1988, I participated in a meeting with Charles Vick and Clyde Reynolds, the president of H & H, where my illness (AIDS) was discussed. It was my naive belief that H & H would work to accommodate me in anyway they could, as I had always been a trusted and loyal employee.

"On or about August 3, 1988, the bottom fell out when I received a letter from H & H notifying me that my insurance coverage had changed effective August 1, 1988, and that the new insurance had a lifetime cap of Five Thousand ($5,000.00) Dollars for AIDS-related benefits. Clyde Reynolds told me that Mr. Everett, the owner of H & H, had made the decision to change insurance policies.

"On August 26, 1988, Robert Michels, an agent for General American, met with me and approximately eleven (11) H & H managers to discuss the change in insurance coverage. He told us that the change was the product of three (3) months of negotiations between General American and Mr. Everett.

"I asked Mr. Michels about the possibility of

my continuing to receive coverage under the old policy, and he told me that the policy had been terminated and was not an available option. He said there was no way I could purchase continuing coverage as an individual, either.

"I also attended a later meeting, on August 26, 1988, with just Mr. Michels and Clyde Reynolds. In this meeting Mr. Michels said that the new, selfinsured plan presented by H & H was subject to federal law and that if, at any time, federal law declared that discrimination against AIDS patients by reduction of benefits was illegal, my benefits would revert to those enjoyed by other H & H employees.

"To the best of my knowledge, I am the only employee of H & H who was affected by this change in coverage for AIDS-related illnesses; I know of no other employee of H & H with a previously covered condition who has been affected by the change.

"Until August 1, 1988, my insurance coverage through my employment at H & H provided me with a lifetime major medical maximum of One Million ($1,000,000.00) Dollars.

"I have exhausted the Five Thousand ($5,000.00) Dollars of coverage, and I am now compelled to pay for my medical care out of my diminished savings, and to weigh my proposed treatments against my own ability (or inability) to pay.

"I have no doubt that my medical condition and the prospects of my future utilization of my insurance for my medical condition was the prime motivator in their change in my coverage. Very simply, all that I now seek is restoration of my medical insurance coverage for a condition over which I had no choice in contracting, and which requires the protection of my insurance to combat.

"Further, Affiant sayeth not."

/s/ (illegible)

SWORN TO AND ACKNOWLEDGED BEFORE ME this 30th day of January, 1990.

/s/ Jackie K. Piper
Notary Public in and for
the State of Texas
/s/ Jackie K. Piper
Printed Name of Notary Public

My commission expires: 11/27/93

Plaintiff's Affidavit

H & H MUSIC COMPANY

General Offices:
11577 OLD KATY ROAD
HOUSTON, TEXAS 77043
(713 531-9222

Houston's Largest Full Line Music Company
"Since 1945"

July 28, 1988

Dear Valued Employees:

For many years we have provided a health insurance program for you and your dependents. Over the years, this plan has been responsible for heading off financial disaster which surely would have struck many families within the H & H Music Company family had it not been for this plan.

Over the last several years, the losses for the plan have mounted steadily. Last year the plan suffered financial disaster. For every dollar that was received in premium, almost $1.50 was spent in benefit payments. When you add to this the cost of paying the claims, administering the plan, and estimating the future impact of 20% inflation in medical cost, you can see that something drastic had to be done to save the plan. A time for tough decisions has come!

With these thoughts in mind, we were faced with either dropping the plan completely or redesigning the benefits so that we hopefully can get cost back under control; therefore, effective August 1, 1988, the following changes will be made to your medical plan:

1. Increase the calendar year deductible to $300.00.
2. Increase the individual stop-loss to $10,000 per calendar year. That is, the plan will pay 80% of covered expenses to $10,000 and then 100% of the remaining covered expenses for

the balance of the calendar year.

3. Limit treatment of AIDS to $5000.00. per individual lifetime.
4. Exclude all treatment for chemical dependency (drug abuse and alcoholism).
5. Add the Sanus/Passport Preferred Provider Network and Utilization Review to the program. This arrangement will essentially allow you to choose physicians and hospitals which have negotiated with us to provide medical care on a reduced precontract fee basis. There will be financial incentives for you to use the providers on a preoccurrence basis. It will be a freedom of choice plan. Because of the complexities involved and the education required, there will be manager briefings for this program by the end of August or first of September. Then the managers will brief the employees on the benefits of this arrangement.
6. Increase employee contributions by $2.75 per pay day for individual coverage and $17.50 per day for family coverage.

While the decisions we had to make in order to save the plan were tough, we think that these changes will save the financial integrity of the plan and continue to allow it to provide financial security to the employees and their families of H & H Music Company.

Sincerely yours,
/s/_____
William C. Everitt

SCHEDULE PAGE

The amounts shown below are the maximum amounts payable as subsequently explained:

Employee Only Insurance Coverage:

	Benefit Amounts
Life Insurance	(See most recent
Accidental Death and	certification form
Dismemberment Insurance	for amounts)

Modification of Insurance Schedule

The amount of Life and Accidental Death and Dismemberment Insurance of an employee less than age 65 shall be reduced to 65% of the otherwise applicable amount on his 65% birthday.

In no event shall an employee's Accidental Death and Dismemberment Insurance be more than $20,000.00 on or after his 70th birthday.

The Accidental Death and Dismemberment Insurance may not be converted to an individual policy.

EMPLOYEE AND DEPENDENT INSURANCE COVERAGE:

MEDICAL CARE INSURANCE;

Major Medical Expense:

Major Medical Maximum $1,000,000.00

Deductible Amount -- an amount of covered expenses to which the deductible requirement applies equal to the

Individual Deductible Amount of.....200.00

or the Family Deductible Amount of.....600.00

No part of any covered expenses for which benefits are paid or payable under the Insured Portion may be used to satisfy the Family Deductible Amount.

The family deductible must be satisfied by the employee and members of his family insured as dependents.

The Benefits Maximum and the Deductible Amount shown above are subject to adjustment in the case of a person who has received benefits or incurred changes subject to the deductible, or both, under the Schedule previously in effect.

Deductible Accumulation Period -- full calendar year (or end of next calendar year when expenses are "carried over" from one calendar year to the next, as explained in the Deductible Requirement provision on a Major Medical benefits description page).

Additional Deductibles:
A) For Inpatient Hospital Confinement:
MCB-81-SCH-(5353) -1-

Contributions to Plan:
You pay a portion of the cost to insure yourself and your dependents.

Termination of Amendment of Plan:
The Plan Sponsor may terminate or amend the Plan at any time or terminate any benefit under the Plan at any time. If premiums are not paid to the Insurance Company the benefits issued by the Insurance Company shall terminate at the end of the Grace Period.

The Insurance Company may terminate the benefits provided under the Group Policy by giving 31 days notice to the Plan Sponsor.

If less than 100% of those employees who do not have to contribute for dependent insurance under the Group Policy or less than 75% of those employees who do have to contribute for such dependent insurance are insured for such insurance, the Insurance Company may cancel the dependent insurance by giving notice in writing to the Plan Sponsor at least 31 days prior to the date insurance will end.

Cancellation of the policy or any of its provisions may be without the consent of the Plan Sponsor or any person claiming rights or benefits under the plan. If the policy cancels or any provision ends, it shall not affect any claim which begins before the date the policy or such provision ends, subject to the terms and conditions of the policy.

MAJOR MEDICAL BENEFITS

SCHEDULE

Important Notice
Your Medical coverage includes one or more features to help control medical care costs. Some features will affect the amount of benefits payable for your medical care. See the Cost Containment section of this plan for a further explanation.

Employee and Dependent Coverage	Amounts Applicable To You or a Dependent

Medical Care

Lifetime Maximum For
All Covered Expenses.....1,000,000

Lifetime Maximum for covered expenses incurred for:

1. all treatment of nervous and mental conditions.....$25,000
2. AIDS (Acquired Immune Deficiency Syndrome) and ARC (AIDS Related Complex.....$ 5,000

Deductible Amount - an amount of covered expenses to which the Deductible Requirement applies equal to:

the Individual Deductible
Amount of.....$ 300
or the Family Unit Deductible
Amount of.....$ 900

The Family Unit Deductible must be satisfied by you and your family unit member's covered as dependents.

No part of any covered expenses for which benefits are paid or payable by the plan may be used to satisfy the Family Unit Deductible Amount.

<u>The following is Applicable When Services of a Participating Provider Are Utilized:</u>

Deductible

Services	The Plan Will Pay	Applies
1. Outpatient Diagnostic X-ray and Laboratory Service Charges incurred due to injury or illness (includes pre-admission testing)	100%	No
2. Outpatient Surgery and Anesthesia Service Charges	100%	No
3. Outpatient Hospital Charges for Medical Care, Services and supplies in connection with surgical procedures or injuries	100%	No

No. 91-1283

Supreme Court, U.S.
FILED
OCT 16 1992
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1992

FRANK GREENBERG, INDEPENDENT EXECUTOR OF ESTATE OF JOHN W. MCGANN, DECEASED, PETITIONER

v.

H & H MUSIC COMPANY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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BEST AVAILABLE COPY

QUESTION PRESENTED

Whether an employer violated Section 510 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1140, which prohibits various forms of interference with employee rights created or protected by ERISA, by amending its health benefit plan to reduce coverage for AIDS-related illnesses after learning that an employee had AIDS.

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In the Supreme Court of the United States

OCTOBER TERM, 1992

No. 91-1283

FRANK GREENBERG, INDEPENDENT EXECUTOR OF ESTATE OF JOHN W. MCGANN, DECEASED, PETITIONER

v.

H & H MUSIC COMPANY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATUTORY PROVISION INVOLVED

Section 510 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1140, provides:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act [29 U.S.C. 301 *et seq.*], or for the purpose

of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter or the Welfare and Pension Plans Disclosure Act. The provisions of section 1132 of this title shall be applicable in the enforcement of this section.

STATEMENT

1. In December 1987, Jack McGann, an employee of respondent H & H Music Company, discovered that he had AIDS. He subsequently began to request reimbursement for AIDS-related medical expenses under H & H's group insurance plan which, at the time, provided up to $1 million in lifetime medical benefits for all employees. In March 1988, H & H officials discussed McGann's illness with him.

A few months later, H & H informed its employees that, effective August 1, 1988, it was becoming self-insured and was changing some of the plan's coverage and benefit provisions. Those changes included a reduction in the lifetime maximum payment for AIDS treatment from $1 million to $5,000. No similar limitation was placed on treatment for other diseases. Under the terms of the amended plan, McGann was unable to recover the substantial medical costs he incurred in the treatment of his illness. Pet. App. A2-A4, A35-A36; H & H Br. in Opp. App. 25a-26a.

2. In August 1989, McGann sued H & H, the plan's administrator, and its former insurer (collectively H & H) for violating Section 510 of ERISA.[1] Pet. App. A4.

[1] Respondent Brook Mays Music Co. was the administrator of H & H's plan while it was insured. Respondent General American

The complaint included claims for damages based upon the amount of McGann's uninsured medical expenses. H & H Br. in Opp. App. 8a-9a, 14a-15a.

a. Section 510 provides, in pertinent part, that an employer may not "discharge" or "discriminate against" a plan participant "for exercising any right to which he is entitled under the provisions of an employee benefit plan [or ERISA] * * * or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan." 29 U.S.C. 1140. McGann alleged that the reduction in the lifetime maximum coverage for AIDS treatment violated both the "retaliation" clause of Section 510 (discrimination "for exercising any right") and the "interference" clause (discrimination "for the purpose of interfering with the attainment of any right"). H & H Br. in Opp. App. 8a.

b. Respondents filed a motion for summary judgment supported by an evidentiary submission detailing the circumstances surrounding the August 1, 1988, plan amendments. Respondents' submission indicated that the terms of the plan permitted H & H to alter its coverage obligations at any time, and that H & H had notified its employees of this feature of the plan in accordance with the disclosure requirements of ERISA. Pet. App. A38. After H & H learned of McGann's illness, it decided to exercise its option to make changes in the benefits provided for the stated purpose of "preserving the financial integrity of the welfare plan." H & H Br. in Opp. App. 6a; Pet. App. A38.

Life Insurance Co. was first the insurer of H & H's plan and later the administrator of H & H's self-insured plan. McGann alleged that they conspired with H & H to violate Section 510 and that the respondents also violated various state laws. Respondents contended that the state law claims were preempted by ERISA, the district court dismissed those claims, and McGann did not appeal the dismissal. See Pet. App. A5 & n.22.

The affidavits included other evidence which, if true, would further support H & H's assertion that the changes in coverage were motivated by cost considerations. In the preceding years, the plan had suffered serious financial losses. Pet. App. A38. Premiums received from the employees in the prior 12-month period covered only two-thirds of the cost of the benefits paid. H & H Br. in Opp. App. 4a. Further, the changes in coverage were not limited to the imposition of a $5,000 cap on AIDS-related treatment. Among other things, the amount of the deductible was increased by 50%; employee contributions were increased by $17.50 per payday for family coverage; all treatment for drug and alcohol dependency was excluded; and a preferred provider program was adopted. *Id.* at 5a-6a.

McGann filed an affidavit in opposition to summary judgment. His affidavit stated that he submitted claims for treatment expenses in December 1987 or January 1988, and advised his manager in early 1988 that he had AIDS. H & H Br. in Opp. App. 22a. McGann further indicated that he was the only employee affected by the change in AIDS coverage, and that he had "no doubt that my medical condition and the prospects of my future utilization of my insurance for my medical condition was the prime motivator in [respondents'] change in my coverage." *Id.* at 23a. McGann did not adduce any other evidence that H & H had any animus against him, against persons with AIDS, or against persons who had exercised rights conferred by the benefit plan. McGann did not file an affidavit under the terms of Federal Rule of Civil Procedure 56(f) explaining why further discovery would be necessary to enable him to rebut respondents' evidence.

c. The district court granted summary judgment in favor of respondents, concluding that the undisputed facts established that respondents had not violated Section 510. Pet. App. A34-A43. The court first found that ERISA does not require employers to provide any particular bene-

fits, and does not prohibit employers from offering different types of coverage for different illnesses. *Id.* at A37. The court also noted that the summary plan description that H & H provided to employees pursuant to 29 U.S.C. 1022(a)(1) "included a paragraph clearly stating that the plan sponsor could terminate or amend the Plan or terminate any benefit under the Plan at any time." Pet. App. A39. The district court went on to reject McGann's discrimination claim because H & H "had the right to change or terminate the medical plan under ERISA" and "the action was not taken to interfere with the rights of McGann but to ensure the future existence of the plan." *Id.* at A41.

3. The court of appeals affirmed. Pet. App. A1-A33. It first stated that McGann had to demonstrate H & H's "specific intent" either (1) to retaliate against him for "filing claims for AIDS-related treatment" or (2) to interfere with his "attainment of any right to which he may have become entitled." *Id.* at A10. With respect to McGann's retaliation claim, the court held that McGann had failed to offer evidence that would support the inference that H & H acted with the intent to retaliate against him for filing benefit claims. To the contrary, the court concluded, the record showed that H & H's motive was to avoid paying for AIDS treatment "no more for McGann than for any other present or future plan beneficiary who might suffer from AIDS." *Id.* at A10-A11.

With respect to McGann's interference claim, the court held that McGann had failed to show that H & H interfered with a right to which he "may [have] become entitled" under the plan because the continued availability of a $1 million coverage limit was not such a right. "The right referred to in the second clause of section 510 is not simply any right to which an employee may conceivably become entitled," the court reasoned, "but rather any right to which an employee may become entitled pursuant to an existing, enforceable obligation assumed by the em-

ployer." Pet. App. A11-A12. Here, H & H specifically retained discretion to modify plan coverage at any time. *Id.* at A12-A13. To accept McGann's argument, the court stated, effectively would mean that an employer could not reserve the right to amend its plan. *Id.* at A13-A14.

The court of appeals found unpersuasive McGann's reliance on Section 510 cases involving wrongful discharge. Section 510 specifically prohibits a "discharge" undertaken "for the purpose of interfering with the attainment of any right." The cases cited by McGann were resolved under that portion of Section 510, and did not address the very different question of when an employer's amendment of the terms of a plan can be characterized as unlawful "discrimination." Pet. App. A16 & n.27.[2] In the court's view, the cases more relevant to this issue were those holding that ERISA gives an employer the right to amend its welfare benefit plans and does not require different groups of participants to be treated equally. *Id.* at A19-A26. The court concluded that "ERISA does not broadly prevent an employer from 'discriminating' in the creation, alteration or termination of employee benefit[] plans," and Section 510 "does not prohibit an employer from electing not to cover or continue to cover AIDS, while covering or continuing to cover other catastrophic illnesses, even though the employer's decision in this respect may stem from some 'prejudice' against AIDS or its victims generally." Pet. App. A29-A30. Such discrimination

[2] The court also distinguished *Vogel* v. *Independence Federal Savings Bank*, 728 F. Supp. 1210 (D. Md. 1990), the only case cited by McGann "in which a court has ruled that a change in the terms and conditions of an employee-benefit[] plan could constitute illegal discrimination under section 510." Pet. App. A16. In that case the employer changed insurers, and the new policy "covered all previously covered employees * * * with the exception of Leonard Vogel." 728 F. Supp. at 1216. The court noted that in this case, in contrast, "[t]he post-August 1, 1988 $5,000 AIDS coverage limit applies to any and all employees." Pet. App. A18.

is illegal under ERISA, the court stated, "only if it is motivated by a desire to retaliate against an employee or to deprive an employee of an existing right to which he may become entitled." *Id.* at A30-A31.

4. McGann died in June 1991, while the case was under submission to the court of appeals. Frank Greenberg, the executor of his estate, filed a petition for a writ of certiorari seeking review of the Fifth Circuit's judgment.

DISCUSSION

This case implicates health care policy issues of serious concern to the United States. McGann lost insurance coverage for the treatment of AIDS at the time it was needed most—when his medical condition effectively foreclosed the purchase of alternate insurance and treatment costs could exceed his means. Efforts are under way at the state and federal level to regulate health insurance plans in a manner that minimizes the potential for such personal hardship, while at the same time affording employers the flexibility needed to guard against unmanageable costs.

The issue here, however, is a narrow one—the meaning and scope of Section 510 of ERISA. In our view, the court of appeals correctly held that nothing in that provision prohibited H & H from adopting a plan amendment that disadvantaged persons with AIDS for the purpose of reducing plan costs. Any other interpretation cannot be reconciled with provisions of ERISA that more directly address the validity of the plan terms at issue here. Those provisions establish that Congress decided not to prohibit plan amendments reducing existing health care benefits, 29 U.S.C. 1051(1), 1054(g); not to "proscribe discrimination in the provision of employee benefits," *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); and not to "regulate the substantive content of welfare-benefit plans." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985).

The decision of the court of appeals does not conflict with the decision of any other court, and the gravamen of the complaint—fairness to persons who are sick or disabled—is a subject that has now been addressed by the Americans with Disabilities Act of 1990 (ADA). We accordingly do not believe that further review is warranted in this case.

1. a. This case essentially involves the enforceability of two terms in the H & H benefit plan: one which reserved the right to amend the plan to reduce or eliminate coverage at any time, and one which provided less favorable treatment to persons suffering from AIDS. In provisions governing the permissible content of employee benefit plans, set forth in Part Two of Subtitle B of Subchapter I of ERISA (Part Two), 29 U.S.C. 1051-1061 (1988 & Supp. II 1990), Congress directly identified certain plan terms that are required or prohibited. It is therefore significant, as the court of appeals concluded, that Part Two of ERISA would clearly permit an employer to include the two terms at issue in its employee health insurance plan.

The Court's decision in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983), confirms that by declining to regulate the content of the terms of health plans, ERISA "does not itself proscribe discrimination in the provision of employee benefits," *id.* at 91. As a result, terms differentiating among diseases are permitted. The same is true with respect to terms reserving the right to amend a health care plan to reduce existing coverage at any time. Although Congress mandated that *pension benefits* must vest, 29 U.S.C. 1053(a) (1988 & Supp. II 1990), and restricted an employer's right to amend pension plans by altering the vesting schedule, 29 U.S.C. 1053(c) (1988 & Supp. II 1990), or decreasing accrued benefits, 29 U.S.C. 1054(g), Congress specifically provided that these limitations did not apply to *health benefit plans*, 29 U.S.C.

1051(1).[3] See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732 (1985) (observing that ERISA "imposes upon pension plans a variety of substantive requirements relating to participation * * * and vesting" but that it "does not regulate the substantive content of welfare-benefit plans").

Instead of regulating the content of self-insured employee health plans, ERISA adopted the rule that a participant's right to benefits are, by and large, those defined by the terms of the contract.[4] See 29 U.S.C. 1132(a)(1)(B) (participant may sue "to recover benefits due to him *under the terms of his plan*") (emphasis added). There is no claim in this case, however, that H & H did not pay benefits in accordance with the terms of the plan, or that the amendments were not adopted in conformance with the requirements of the plan.[5] Petitioner's right to recover benefits must accordingly turn on whether the plan amendments in issue, although facially legitimate under Part Two of ERISA, nevertheless violated Section 510, 29 U.S.C. 1140.

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[3] Congress has provided that plans must provide for the continuation of health coverage in certain circumstances. For example, a group health plan must provide that a terminated employee is eligible to continue to be covered for a period of time ranging from 18 months to 36 months. See 29 U.S.C. 1161(a), 1162(2) (1988 & Supp. II 1990), 1163(2). If coverage for employees is modified, continuation coverage is modified in the same manner. 29 U.S.C. 1162(1).

[4] States may mandate that *insured* health benefit plans provide certain benefits, however. *Metropolitan Life*, 471 U.S. at 739-747 (upholding a Massachusetts law requiring insurance companies to provide specified minimum mental health care benefits in any health insurance plan offered in the State). Such laws do not apply, however, to self-funded employer plans such as the one in issue here.

[5] The terms of some plans may permit amendments with a purely prospective impact only, and preclude plan amendments, such as the one in issue, which also eliminate continuing coverage for individuals with pre-existing conditions. Such issues of plan interpretation may be raised in a benefit claim action under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B). No such claim was made here.

b. As this Court recognized in *Ingersoll-Rand Co.* v. *McClendon*, 111 S. Ct. 478, 485 (1990), Section 510 was "crucial" to the scheme of regulation adopted by Congress so that "employers would [not] be able to circumvent the provision of promised benefits." See also *Dister* v. *Continental Group, Inc.*, 859 F.2d 1108, 1111 (2d Cir. 1988) (stating that Section 510 "was designed primarily to prevent 'unscrupulous employers from discharging or harassing their employees in order to keep them from obtaining vested pension rights,'" quoting *West* v. *Butler*, 621 F.2d 240, 245 (6th Cir. 1980)).[6] By way of example, an employer who is not entitled to amend a plan to prevent the imminent vesting of an employee's pension benefit under Part Two of ERISA, should not be able to circumvent that statutory requirement by terminating the employee.

Consistent with that purpose, Section 510 prohibits certain types of conduct—any action to "discharge, fine, suspend, expel, discipline, or discriminate against a participant"—inflicted for the specific purpose of interfering with rights protected by the plan or ERISA. Section 510 does not broadly prohibit all types of "discrimination" against participants. Like other similar laws, its limited terms make clear that Section 510 only prohibits discrimination undertaken for the purposes expressly made "impermissible" (see *Furnco Construction Corp.* v. *Waters*,

[6] In *Dister*, for example, the plaintiff alleged that he had been discharged four months before he would have qualified for early retirement, resulting in a loss to him of $550,000. 859 F.2d at 1115. Congress had specifically contemplated that Section 510 would bar discharges that were intended to prevent employees from vesting: Senator Hartke stated that "[t]he key to effective pension reform is early vesting, but a vesting provision is no better than the protection employees have against improper discharge—including layoff discipline or other discrimination that puts an employee out of a job before vesting is achieved, thereby defeating his pension claim." 1 Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., *Legislative History of the Employee Retirement Income Security Act of 1974*, at 1244 (Comm. Print 1976); see also *id.* at 1641 (statement of Sen. Javits).

438 U.S. 567, 577 (1978)) by the terms of the statute. See, *e.g.*, *Espinoza* v. *Farah Mfg. Co.*, 414 U.S. 86, 95 (1973) (discrimination against aliens did not violate Title VII because it is not among the "kinds of discrimination the Act makes illegal").

The court of appeals was thus correct in its conclusion that the facially legitimate plan amendment at issue could only be unlawful under Section 510 if it was adopted for the purpose of retaliating against a participant "for exercising any right * * * under the * * * plan [or ERISA]" or "for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan [or ERISA]." 29 U.S.C. 1140.[7] Inclusion of the discriminatory amendment for any other reason, whether due to racial or social animus, is simply not forbidden by the plain language of Section 510.

The correctness of the ruling below accordingly turns on whether there was sufficient proof in the record of the "kinds of discrimination," *Espinoza*, 414 U.S. at 95, prohibited by Section 510. We share the court of appeals' view that there was not.

2. a. Turning first to the retaliation clause of Section 510, we do not believe that the record created a genuine issue of fact on the question whether H & H amended the plan for the "impermissible" purpose of discriminating against McGann "for exercising any right to which

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[7] In our view, Section 510 is applicable to plan amendments made for purposes prohibited by that Section, and is not limited to protection of the overall employment relationship. But see, *e.g.*, *Deming* v. *American Standard, Inc.*, 905 F.2d 1124, 1127 (7th Cir. 1990). Thus, for example, plan amendments made in retaliation for filing a breach of fiduciary duty action should be unlawful. We also do not believe that there is any basis in the language of Section 510 for limiting the reach of the provision to employers. See Gen. Am. Br. in Opp. 15-19. The provision applies to "any person," not just employers. And some of the proscribed actions—such as fines and expulsion—appear to be aimed more at unions than employers.

he is entitled under the provisions of an employee benefit plan." As set forth, H & H submitted evidence that the amendment was made for the purpose of reducing plan costs. If true, no violation of Section 510 would have occurred because the terms of ERISA, and the plan in issue, did not prohibit H & H from reducing health benefits for the purpose of saving costs. That is, of course, the reason employers include plan provisions permitting the reduction of benefits—provisions which Congress chose not to prohibit.

In this case, McGann did not rebut the evidence submitted by H & H with any specific factual information suggesting that the amendment was instead motivated by animus towards McGann or other persons who exercised rights under the plan. Instead, petitioner's claim of impermissible discrimination on this record must rest on the view that a prohibited purpose can be inferred from the fact that the amendment had an adverse effect on a participant who had exercised rights under the plan by submitting claims, and/or from the fact that the plan amendment was undertaken with knowledge of, and in response to, McGann's submission of AIDS-related claims. We share the court of appeals' view that these two facts alone were not sufficient to establish a reasonable inference (in light of H & H's contrary evidence) that the plan amendments were made for the impermissible purpose of discriminating against persons who had exercised ERISA-protected rights.

(i) Evidence that an employer's conduct has an adverse impact on persons within a protected class certainly has relevance to issues of motive. But where an adverse effect on a protected group is quite likely to result from entirely permissible conduct, it is less reasonable to infer, based on that effect alone, that the challenged conduct was motivated by forbidden purposes. See, *e.g.*, *Personnel Adm'r* v. *Feeney*, 442 U.S. 256, 279 n.25 (1979) (holding that a preference for veterans that had the effect of

disadvantaging women did not rebut evidence of a non-discriminatory purpose because the adverse impact on the protected group was "essentially an unavoidable consequence of a legislative policy that has in itself always been deemed to be legitimate"). In the context of employee benefit plan administration, it is completely predictable that plan amendments eliminating or reducing certain types of benefits, and which are made for the legitimate purpose of saving costs, will often have a disproportionately adverse effect on persons who have submitted claims for that type of benefit under the terms of the plan. As the Court explained in *Furnco Construction Corp.* v. *Waters*, 438 U.S. 567, 580 (1978), "we infer discriminatory animus" where "experience has proved that in the absence of any other explanation it is more likely than not that those actions were bottomed on impermissible considerations," and evidence of discrimination must be evaluated "in light of common experience." *Id.* at 577. Because plan amendments motivated by permissible cost considerations will often adversely affect participants who have asserted rights under a plan, "common experience" dictates that evidence of such an effect on McGann was not alone sufficient to rebut H & H's evidence of permissible motives.

(ii) For similar reasons, the fact that submission of a claim for benefits has a causal connection with a subsequent reduction in coverage does not itself provide a sufficient basis for inferring impermissible discrimination against persons who exercise protected ERISA rights, at least on the facts of this case. An amendment designed to save money would normally (and reasonably) be based on experience under the plan, so that, for example, an amendment that decreases dental benefits should not be held unlawful because the amendment was prompted by expensive claims for dental benefits.[8] A holding that

[8] Such a decrease would not be materially different from the limitation at issue in *Tackitt* v. *Prudential Ins. Co.*, 758 F.2d 1572

a plaintiff like petitioner has a viable retaliation claim would mean, in effect, that health benefits vest—once a participant files a claim for some type of benefit, the benefit may not be decreased. But as we have described, Congress did not require plans to provide vested *health* benefits.

(iii) We do not suggest that a participant adversely affected by a discriminatory plan amendment would never be able to establish a reasonable inference that the amendment was made for impermissible purposes. For example, if a participant who files a breach of fiduciary duty action—a right protected by ERISA—is singled out for adverse treatment under a health plan amendment, there would be a strong inference that the amendment was made for an impermissible retaliatory purpose. That inference might well be strong enough to create a genuine issue of pretext even if the employer submitted evidence that the amendment was supported by cost considerations. As we view this case, however, what is missing is any cognizable argument that H & H's justification for its amendment was pretextual. As the court of appeals concluded, "there is nothing in the record to suggest that [respondents'] motivation was other than as they asserted, namely to avoid the expense of paying for AIDS treatment * * *, no more for McGann than for any other present or future plan beneficiary who might suffer from AIDS." Pet. App. A10-A11.

(11th Cir. 1985). In that case, the Office of Personnel Management (OPM) approved an amendment to a federal health care plan that limited home nursing payments to $2,500 per year. The reduction was designed, along with other changes, to avoid an increase in premiums. A retired federal employee who previously had been reimbursed for home nursing expenses of $80,000 per year challenged the amendment under the Administrative Procedure Act, alleging that OPM's decision to approve the benefit change was arbitrary and capricious. The court rejected the challenge.

b. Turning to the second kind of discrimination forbidden by ERISA, the record also did not establish that H & H reduced AIDS treatment "for the purpose of interfering" with McGann's "attainment of any right" to which he might have become "entitled" within the meaning of Section 510. As the court of appeals explained, the clause does not refer to "any right to which an employee may conceivably become entitled," but to "any right to which an employee may become entitled pursuant to an existing enforceable obligation assumed by the employer." Pet. App. A11-A12. On this record, it was appropriate for the court to conclude that H & H was simply exercising its own reserved right to amend its plan to reduce expenses, and did not thereby impermissibly interfere with any right protected under Section 510.

Petitioner's reading of Section 510 simply cannot be reconciled with the statute. Instead of preventing "circumvent[ion] * * * of * * * promised benefits," *Ingersoll-Rand*, 111 S. Ct. at 485, that reading of Section 510 would effectively create rights and benefits that were never promised by the employer and never mandated by Congress.

First, petitioner's construction would effectively prohibit any discrimination among types of illnesses, contrary to the Court's conclusion that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *Shaw*, 463 U.S. at 91. Consistent with the premise stated in *Shaw*, health benefit plans routinely discriminate among participants suffering from different types of illnesses. Many plans, for example, limit coverage for mental illness. Such discrimination has never been called into question under ERISA, by any court, or the Department of Labor, which administers the relevant provisions of the Act. Under petitioner's construction of Section 510, however, such pro-

visions would be unlawful because their purpose necessarily is to prevent persons with mental disorders from the "attainment of any right" to treatment under the terms of the plan. Section 510 cannot reasonably be read in that manner.

Second, petitioner's reading of Section 510 would also result in the vesting of health care benefits—a result Congress clearly chose not to mandate under Part Two of ERISA—because any plan amendment reducing existing coverage would necessarily interfere with the "attainment" of a participant's "right" to continue to make such claims in the future. It is therefore only reasonable to conclude that when the sponsor of a plan has reserved an absolute right to amend its plan, an employee has no "right" protected by this clause of Section 510 to prevent plan amendments made for the purpose of altering existing coverage to save costs.

As the Seventh Circuit explained in a case involving an amendment reducing benefits, "[t]o say that the * * * provision was eliminated in order to prevent the [employees] from obtaining the benefits of the * * * provision is a tautology which highlights the fact that this sort of allegation cannot support a § 510 claim." *Deeming* v. *American Standard, Inc.*, 905 F.2d 1124, 1127 (1990). Any other conclusion would effectively negate an employer's right to amend plans to decrease benefits, despite Congress's determination that such a right was important to the statutory scheme adopted. See *Moore* v. *Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) ("[w]ith regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility" due to "inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation").

3. On balance, we are not persuaded that this case warrants review. Although the issue itself is important, no court of appeals has adopted a conflicting interpreta-

tion of Section 510. Accordingly, review is unnecessary at this time to ensure the uniformity of lower court decisions interpreting ERISA. We instead believe that the issues of health care policy implicated by this case are more appropriately addressed in the context of other existing federal law and pending legislative initiatives.

a. A fair reading of the complaint and affidavit submitted by McGann suggests that this case is really about discrimination against persons with AIDS, and not discrimination against persons exercising ERISA-protected rights. Since this case was litigated, however, the law has changed considerably. The legality of such discrimination under the terms of employee benefit plans will undoubtedly be tested in cases arising under the Americans with Disabilities Act of 1990 (ADA), which took effect for most employers in July of 1992. See Pub. L. No. 101-336, § 108, 104 Stat. 337 (1990) (42 U.S.C. 12111 note (Supp. II 1990)).

The ADA prohibits discrimination against disabled individuals with respect to compensation and "other terms, conditions, and privileges of employment." ADA § 102(a), 104 Stat. 331-332 (42 U.S.C. 12112(a) (Supp. II 1990)). Since the courts have held that AIDS is a protected handicap under the Rehabilitation Act of 1973, see, *e.g.*, *Severino* v. *North Fort Myers Fire Control Dist.*, 935 F.2d 1179, 1182 n.4 (11th Cir. 1991), and the ADA's definition of disability is substantially the same as the Rehabilitation Act's definition, see 29 U.S.C. 706(8)(B) (1988 & Supp. II 1990) and ADA § 3(2)(A), 104 Stat. 329-330 (42 U.S.C. 12102(2)(A) (Supp. II 1990)), persons with AIDS are protected by the ADA. See EEOC, *ADA Handbook*, at I-28 (1991). Accordingly, discrimination against persons with AIDS in the provision of employee benefits is unlawful under the ADA unless the challenged action is protected by the provision of the ADA allowing insurers and plan administrators to observe the terms of "a bona fide benefit plan" that is not "used as a

subterfuge" to evade the purposes of the ADA. ADA § 501(c), 104 Stat. 369-370 (42 U.S.C. 12201(c) (Supp. II 1990)).

Because Congress directly addressed the subject of AIDS discrimination in employee benefit plans under the ADA, claims such as that in issue will likely turn on the requirements imposed on employers under that law. The need for review in this case is therefore further diminished.

b. This case also raises an issue of health care policy beyond discrimination against AIDS—whether health insurance plan amendments reducing or eliminating coverage for a particular type of illness should be applicable to persons, like McGann, already suffering from that illness. In some cases an employee may be able to prevail in a benefit claim action under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), based upon a claim that, under the terms of the plan, the employer did not in fact reserve an unfettered right to amend the plan, but instead promised to pay all expenses resulting from a disease an employee contracts prior to the date of the amendment. But the scope of the promise made by an employer depends on the terms of the plan at issue and that question would be addressed in a benefit claim action under Section 502(a)(1)(B). No such question is presented in this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

—v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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No. 91-1283

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1992

FRANK GREENBERG, Independent Executor of the Estate of JOHN W. "JACK" McGANN,

Petitioner,

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITIONER'S SUPPLEMENTAL BRIEF

Pursuant to Rule 15.7 of the Rules of the Court, petitioner submits this supplemental brief to address issues raised in the intervening brief filed by the United States.

DISCUSSION

This case raises an unresolved issue of extraordinary importance to millions of Americans, especially those who receive their health care through self-insured benefit plans offered by employers.[1] The

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[1] A "self-insured" health benefit plan is one in which the employer assumes direct liability for the medical expenses of its employees. See generally Rublee, Self-Funded Health Benefit Plans, 255 JAMA 787 (1986). Although as recently as 1974 only five percent of American workers were covered by self-insured plans, today more than sixty percent of employees receive their health care through such plans. Gladwell, When Benefits Changes Leave Employees Vulnerable, Wash. Post, Aug. 20, 1992, at A1, A4. See also Foster Higgins, Health Care Benefits Survey 15 (1991).

issue is this: In enacting Section 510 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1140, prohibiting discrimination against plan beneficiaries, did Congress intend to allow employers absolute discretion to eliminate or reduce a worker's health benefits in response to the submission of claims for reimbursement, if the employer would save money based on the changes?

The United States concedes the significance of the issue, noting that this case "implicates health care policy issues of serious concern." U.S. Brief at 7. The public attention accorded the case underscores its importance.[2]

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[2] The American Medical Association, the American Hospital Association, the United States Conference of Mayors, the American Association of Retired Persons, the American Bar Association and the National Commission on AIDS, among other groups, have all criticized publicly the

In justifying its recommendation that this Court not review the Fifth Circuit's decision, the United States argues that the court below correctly interpreted the meaning and scope of Section 510. Id. The United States also asserts that the decision "does not conflict with the decision of any other court." Id. at 8. Finally, the government contends that "the gravamen of the complaint" will be litigated in the future under the Americans with Disabilities Act of 1990,

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ruling below and have urged the United States to recommend to this Court that it review the decision. See Pear, U.S. Is To Argue Employers Can Cut Health Insurance, N.Y. Times, Oct. 16, 1992, at A1, A18. The national press has also denounced the ruling below. See, e.g., He Thought He Had Insurance, Wash. Post, Oct. 19, 1992, at A20 (editorial characterizing this case as "intolerable"); Tragic Case Shows Need for New Health Care Rules, U.S.A. Today, May 27, 1992, at 8A (editorial asserting that the Fifth Circuit's decision "must not stand").

42 U.S.C. §12101 et seq. (West Supp. 1991) ("ADA"). Id. Petitioner respectfully submits that the first two assertions are demonstrably wrong and that the third offers no basis for denying review.

1. The government's construction of Section 510 is inconsistent with the plain language of the statute.

The United States focuses on a general overview of ERISA and Section 510, making the point that Section 510 was not intended to prohibit discrimination based on race or social animus. U.S. Brief at 10-11. That proposition is not relevant to this lawsuit.

The government also refers to Shaw v. Delta Airlines Inc., 463 U.S. 85 (1983), U.S. Brief at 7, 8, 15, in which the Court, considering preemption issues under ERISA, recognized an employer's broad discretion to set the terms of a welfare

benefit plan. Shaw, however, did not address in any sense the question of what limitations Section 510 places on such employer discretion. The United States answers that question with a resounding "none." Petitioner disagrees and submits that the Shaw Court's acknowledgment of ERISA's comprehensive protection for employees compels a conclusion opposite to that reached by the government. See Shaw, 463 U.S. at 90.

The government argues that an employer which shows that it is motivated to cut the benefits of one employee but not others by the desire to save money is immune from liability, unless the employee can show that the cost-saving justification is a pretext for some improper purpose. U.S. Brief at 12-15. That interpretation ignores the plain

language of Section 510. Section 510 prohibits discrimination based on exercise of any right under the plan. 29 U.S.C. §1140. Its meaning is evident: an employer may not reduce benefits discriminatorily because an employee, like McGann, has exercised his right under the medical plan to file his claims.

The ruling that an employer's desire to save money conclusively demonstrates the absence of discriminatory intent conflicts with the rulings of other appellate courts. See, e.g., Dister v. Continental Group, Inc., 859 F.2d 1108, 1115-16 (2d Cir. 1988).[3] The Third Circuit has reasoned that employer efforts motivated by a desire to cut the costs of

[3] See also Conkwright v. Westinghouse Elec. Corp., 933 F.2d 231, 239 (4th Cir. 1991); Reichman v. Bonsignore, Brignati & Mazzotta, P.C., 818 F.2d 278, 281 (2d Cir. 1987).

funding pensions or other benefits are "exactly th[e] type of conduct" Section 510 proscribes. Gavalik v. Continental Can Co., 812 F.2d 834, 857 n.39 (3d Cir.), cert. denied, 484 U.S. 979 (1987).

Section 510's language reflects Congress's desire to allow employers to cut pension costs or reduce benefit plans so long as the employer is not motivated by the particular claim of an employee. In other words, once the plaintiff has shown that his circumstances prompted the employer's adverse action, the employer must then prove that it did not cut benefits discriminatorily in response to the exercise of a right under the plan. See generally, Price Waterhouse v. Hopkins, 490 U.S. 228 (1989).

The government's own illustration to promote its statutory construction

actually supports petitioner's point. No principled rationale exists for the argument underlying the government's suggestion that if McGann had exercised some right other than filing claims under the plan -- such as filing a claim for breach of fiduciary duty -- he might have prevailed by showing pretext. See U.S. Brief at 14. The government's concession is irreconcilable with its analysis, for Section 510 protects the exercise of rights under both ERISA and a benefit plan covered by ERISA. See 29 U.S.C. §1140.

2. The government's and the Fifth Circuit's construction conflicts with decisions of other courts.

The decision below, as well as the government's interpretation, is inconsistent with basic anti-discrimination law principles applied by other circuits in Section 510 cases.

In rejecting petitioner's reliance on McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973) as the proper framework for analysis of this case and in refusing to recognize that an inference of intentional discrimination arises from the facts of this case, the Fifth Circuit deviated from the holdings of three other courts of appeals (and numerous district courts) that McDonnell Douglas and its progeny apply to Section 510. In circuits other than the Fifth Circuit, petitioner's showing would have been sufficient to establish discriminatory intent. See, e.g., Dister, 859 F.2d at 1114-15.

The Fifth Circuit's factual assumptions regarding defendants' motivation, which must be deemed true under Rule 56, negate the argument that there was insufficient evidence to create

a genuine issue of fact with respect to pretext. See U.S. Brief at 12. Indeed, one of the Fifth Circuit's errors lay in the court's disregarding its own assumption that the defendants' plan changes were motivated by petitioner's having filed claims and having revealed his illness to his employer. Upon the demonstration of a connection between petitioner's filing and the employer's facially discriminatory action, McDonnell Douglas and its progeny provide that the same evidence could establish pretext. See Texas Dep't of Community Affairs v. Burdine, 450 U.S. 248, 255 n.10 (1981).

The United States urges that "common experience" dictates that there can be no reasonable inference of discrimination in this case. U.S. Brief at 13. To the contrary, common experience suggests that

H&H Music, distressed at having to incur the medical expenses of its employee, decided to curtail its obligation by altering its plan to assure McGann's elimination from coverage. Rather than undercutting petitioner's argument, common experience reinforces the inference that the retaliatory discrimination directed at McGann arose because he exercised his right to make claims under the plan. Such discrimination is precisely what Section 510 is meant to prohibit.

3. The Americans with Disabilities Act of 1990 offers no basis for denial of review.

The United States asserts that this case "is really about discrimination against persons with AIDS," and urges against review because, in its opinion, such discrimination "will undoubtedly be tested in cases arising under the

Americans with Disabilities Act of 1990 (ADA)." Id. at 17. However, the government states only that the relevance of the ADA "will... be tested," -- not that it would apply in these circumstances, or even that it should apply. Id.

This case is about discrimination against workers who seek to exercise their rights under an ERISA benefit plan, regardless of illness, and should be determined under ERISA. The government itself recognizes that a full understanding of the ADA section it cites may require years of litigation. Neither employees nor their employers -- and certainly not petitioner -- should be forced to await the eventual interpretation of an entirely different statute when the proper meaning of Section 510 compels resolution.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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